

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05382

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05375

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last Frank Rhodes Adams | | | 2a. DATE OF DEATH Month Day Year April 5, 1969 | | 2b. HOUR a 4:45 M |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH July 27, 1896 | | 6. AGE (In years last birthday) 72 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick, Md. | |
| 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fred. Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. R.R. Express Co. | | 12b. KIND OF BUSINESS OR INDUSTRY None |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Frederick | 13c. CITY OR TOWN Walkersville | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER Frederick Avenue | |
| 14. FATHER'S NAME First Middle Last Lewis B. Adams | | 15. MOTHER'S MAIDEN NAME First Middle Last Daisy M. E. Brust | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. 714-05-6739 | | 17. INFORMANT Address Mrs. Anna P. Adams Walkersville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis (probably lung)</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pneumonia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> , 19 <u>69</u> , to <u>4/5/69</u> , that (I) (we) last saw the deceased alive on <u>4/4/69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>A. Austin Pearre, Jr.</u> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>4/5/69</u> | |
| 22d. PHYSICIAN'S NAME (Type) Dr. A. Austin Pearre, Jr. | | M.D. | | 22e. ADDRESS Toll House Avenue Frederick, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE April 8, 1969 | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick, Frederick, Maryland | |
| 24. FUNERAL DIRECTOR <u>Robert E. Dailey & Son</u> | | ADDRESS Frederick, Maryland | | 25a. REC'D BY REGISTRAR APR 9 1969 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

00882

00882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05383

CERTIFICATE OF DEATH

05376

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Walter Franklin Albert | | | 2a. DATE OF DEATH Month 4 Day 19 Year 69 | | | 2b. HOUR M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 4/14/90 | | 6. AGE (In years last birthday) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | | |
| 10. CITY OR TOWN OF DEATH Brunswick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 700 East B' St. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Brakeman - B. & O. Railroad | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland COUNTY Frederick CITY OR TOWN Brunswick | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET AND NUMBER 700 East B' St. | | | | | |
| 14. FATHER'S NAME First George Middle H. Last Albert | | | 15. MOTHER'S MAIDEN NAME First Ida Middle Mae Last Ray | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT George Albert | | Address Brunswick, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm 277X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 yrs - 30 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-18-1969 to 4-19-1969 , that (I) (we) last saw the deceased alive on 4-18-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE C.E. Pruitt M.D. | | 22c. DATE SIGNED 4-21-69 | | 22d. ADDRESS Brunswick, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 4/21/69 | | 23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery | | 23d. LOCATION (City or Town) (County) (State) Petersville Fred. Md. | | | |
| 24. FUNERAL HOME Frederick Funeral Home | | 25a. REC'D BY REGISTRAR DATE APR 22 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

02393

After

Franklin

Alfred

W. H. H.

W. H. H.

W. H. H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ make carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05384 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05377 | |
|--|---|--|---|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>69</u> | | 2b. HOUR <u>5:05</u> P.M. |
| <u>Idillie</u> | | <u>J.</u> | | <u>Auldridge</u> | | | |
| 3. SEX <u>female</u> | 4. RACE <u>caucasian</u> | | 5. DATE OF BIRTH <u>12/19/79</u> | | 6. AGE (In years last birthday) <u>89</u> YRS. | IF UNDER 1 YEAR MONTHS <u>3</u> DAYS <u>16</u> | IF UNDER 24 HRS. HOURS <u>16</u> MIN. |
| 7a. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Frederick</u> | | Md. |
| 1d. CITY OR TOWN OF DEATH <u>Frederick</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Frederick Nursing Center</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> | | 13b. COUNTY <u>Frederick</u> | | 13c. CITY OR TOWN <u>Burkittsville</u> | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First <u>James</u> Middle <u>Meeks</u> Lost | | 15. MOTHER'S MAIDEN NAME First <u>Isabel</u> Middle <u>Doyle</u> Lost | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/> | | 16b. SOCIAL SECURITY NO. <u>235 -09-2561-D</u> | | 17. INFORMANT Address <u>Davis T. Auldridge, Burkittsville, Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-4 m.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30, 1968</u> to <u>4/4, 1969</u> , that (I) (we) last saw the deceased alive on <u>4/4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Robert S. Hughes</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> NAME (Type) <u>Robert S. Hughes M.D.</u> | | | | 22c. DATE SIGNED <u>4/5/69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS <u>700 Montclair Ave. Fred., Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>4/7/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Burkittsville, Fred., Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Gladhill Co., Middletown, Md.</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <u>APR 8 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>W. Charles Judge</u> | |

05284

| NAME | 1. | Address | 2. | 3. | 4. |
|---------------|----|---------------------------|----|----|----|
| James | | Frederick | | | |
| West Virginia | | U.S.A. | | | |
| Frederick | | Frederick Training Center | | | |
| Frederick | | Frederick | | | |
| Frederick | | Frederick | | | |

NY - 100 -

Frederick, Maryland

Frederick, Maryland

Frederick, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is unnecessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05385

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05378

| | | | | | | | | | | | | | | | |
|--|--|-------------------|--|--|--|------------------------------------|--|--|--|---|--|--|--|----------|--|
| 1. DECEASED NAME (Type or Print) | | First Middle Last | | | | | | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month Day Year | | | | 2b. HOUR | | | |
| Obed Lansdale Beall | | | | | | | | April 10, | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month Day Year | | 2d. HOUR | |
| Male | | White | | Sept. 25, 1901 | | 67 YRS. | | | | | | 1969 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | |
| Maryland | | | | USA | | | | | | | | Frederick | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Frederick | | | | Frederick Mem. Hospital | | | | Painter | | | | Building | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER | | | |
| Md. | | | | Montgomery | | | | Brownsville | | | | RFD # 1, Monrovia | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | |
| Edward T. Beall | | | | L. Imogene Poole | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | | 213-18-9042 | | | | Miss Virgie B. Beall, R#1, Monrovia, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE - Robert R. Skubert M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | | 4/13/69 | | Bethesda Methodist | | | | Brownsville, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Olin L. Molesworth, Damascus, Md. | | | | | | | | APR 15 1969 | | | | Charles Judge | | | |

April 10, 1900

London, England

Dear Sir,

I have the honor to acknowledge the receipt of your letter of the 2nd inst.

in relation to the matter of the proposed extension of the line.

I am sorry to hear that you are unable to attend the meeting.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

Enclosed for you are the reports of the committee on the subject.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

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Yours truly,
J. H. P.

I am, Sir, very respectfully,
Yours truly,
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| 05386 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 05379 | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Raymond | | | | | First L. Middle Bidle Last Bidle | | | | | 2a. DATE OF DEATH Month April Day 6 Year 1969 | | | | | 2b. HOUR 5 p. M. | | | | | | | | | | | | | | |
| 3. SEX Male | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH February 14, 1895 | | | | | 6. AGE (In years last birthday) 74 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Frederick Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 33 East Seventh Street | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | 13b. COUNTY Frederick | | | | | 13c. CITY OR TOWN Frederick | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER 33 E. Seventh Street | | | | | | | | | |
| 14. FATHER'S NAME Charles Middle Bidle | | | | | 15. MOTHER'S MAIDEN NAME First Margaret Middle Marken Last Marken | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. 219 20 4036 A | | | | | 17. INFORMANT Address Frederick, Md. Mrs. Alma Bidle, 33 E. 7th. Street, | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 4121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months 3 years | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertensive Cardiovascular Disease 5 years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 17, 1959 , to Apr 6, 1969 , that (I) (we) last saw the deceased alive on Apr 6, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 5 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Thomas E. Stone | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED 4-6-69 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Thomas STONE | | | | | | | | | | 22e. ADDRESS Frederick, Md | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE April 9, 1969 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State) Middletown Frederick Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR APR 10 1969 | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | |

IN SENATE,
January 11, 1901.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS, 1901.

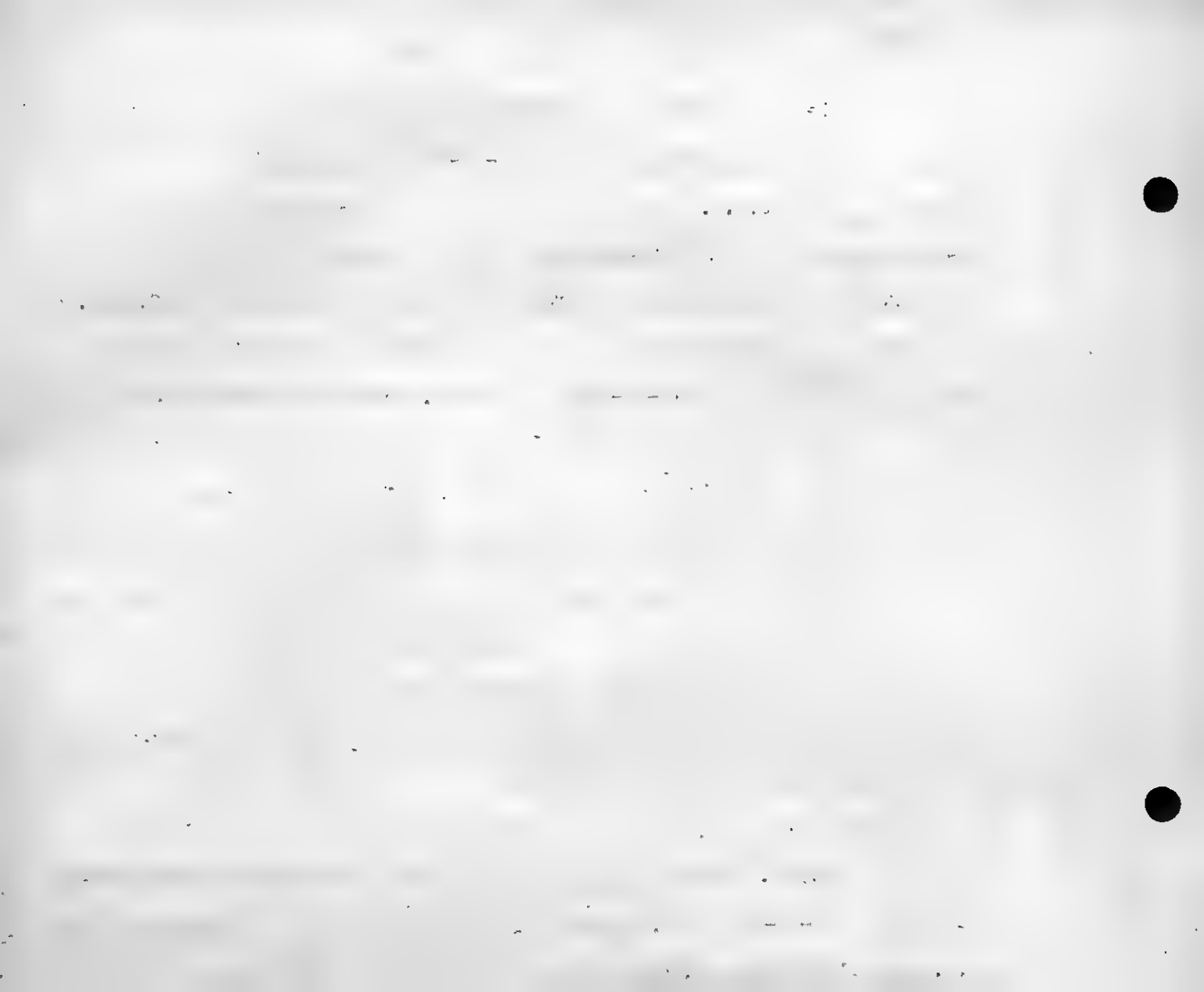
CLARK, NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 5-7-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|-------|---|--|--|
| 05387 | | CERTIFICATE OF DEATH | | | | | | 05380 | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR P M | | |
| Marie Edith Brown | | | | | | April 15 1969 | | | 7:30 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| Female | | Colored | | 2-17-1902 | | | 67 YRS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Md | | U.S.A. | | | | | Frederick Md | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rural (Hopehill) | | | Rt 2 Frederick | | | Canning Factory | | | ***** | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Res. den. before adm.) STATE | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET AND NUMBER | | |
| Md | | | Frederick | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Box 183 A Rt 2, Fred Md | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| John Richard Lee | | | Bessie Harriet Hill | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | |
| No | | | 219-07-8183 | | | Lloyd D. Brown Rt 2 Frederick, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic Heart Disease</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1960, to April 15, 1969, that (I) (we) lost saw the deceased alive on April 15, 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Henry V. Chase</u> | | | | | DEGREE ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 4/16/69 | | |
| 22d. PHYSICIAN'S NAME (Type) Henry V. Chase | | | | | 22e. ADDRESS 804 Toll House Ave Frederick, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 4-18-69 | | Hopehill | | Frederick Md | | | | | |
| 24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md | | | | | 25a. REC'D BY REGISTRAR APR 21 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 05388 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 05381 | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) <i>Mrs Edna JANE Buffington</i> | | | | | | | | | | 2a. DATE OF DEATH Month <i>April</i> Day <i>15</i> Year <i>1969</i> | | | | | | | | | | 2b. HOUR <i>10 35</i> AM | | | | | | | | | |
| 3 SEX <i>F</i> | | | 4. RACE <i>W</i> | | | 5 DATE OF BIRTH <i>AUG 20 - 1896</i> | | | 6 AGE (In years last birthday) <i>72</i> YRS | | | 7 IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | | | 8 IF UNDER 24 HRS. HOURS <i></i> MIN <i></i> | | | | | | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH <i>FREDERICK</i> Md. | | | | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH <i>FREDERICK</i> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>NURSING + CONV. CENTER</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEKEEPER</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i> | | | | | | | | | | | | | | | | | | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MARYLAND</i> | | | 13b. COUNTY <i>CARROLL</i> | | | 13c CITY OR TOWN <i>UNION BRIDGE</i> | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 13e STREET AND NUMBER <i>WHYTE ST.</i> | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First <i>CHARLES</i> Middle <i>CRABBS</i> Last <i>AMELIA</i> | | | 15 MOTHER'S M.A.DEN NAME First <i>COPENHAVER</i> Middle <i>MD</i> Last <i>MD</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO <i>220-44-6498</i> | | | 7 INFORMANT Address <i>CHARLES BUFFINGTON UNION BRIDGE</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4123 Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>SEVERE ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized ASCVD</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Cerebral Thrombosis; Diabetes; Greemian</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i></i> Day <i></i> Year <i>1969</i> | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 31</i> , 1969, to <i>April 15</i> , 1969, that (I) (we) lost saw the deceased alive on <i>April 15</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE <i>A.A. PEARRE SR. MD</i> DEGREE <i>MD</i> | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c DATE SIGNED <i>4/15/69</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) <i>A.A. PEARRE SR.</i> | | | 22e ADDRESS <i>Frederick Md</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | 23b. DATE <i>4/18/69</i> | | | 23c NAME OF CEMETERY OR CREMATORY <i>MT UNION</i> | | | 23d LOCATION (City or Town) (County) (State) <i>UNION BRIDGE RURAL MD</i> | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>D.D. Hertzler & Sons Union Bridge</i> | | | ADDRESS | | | 25a. REC'D BY REGISTRAR <i>APR 18 1969</i> | | | 25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05389

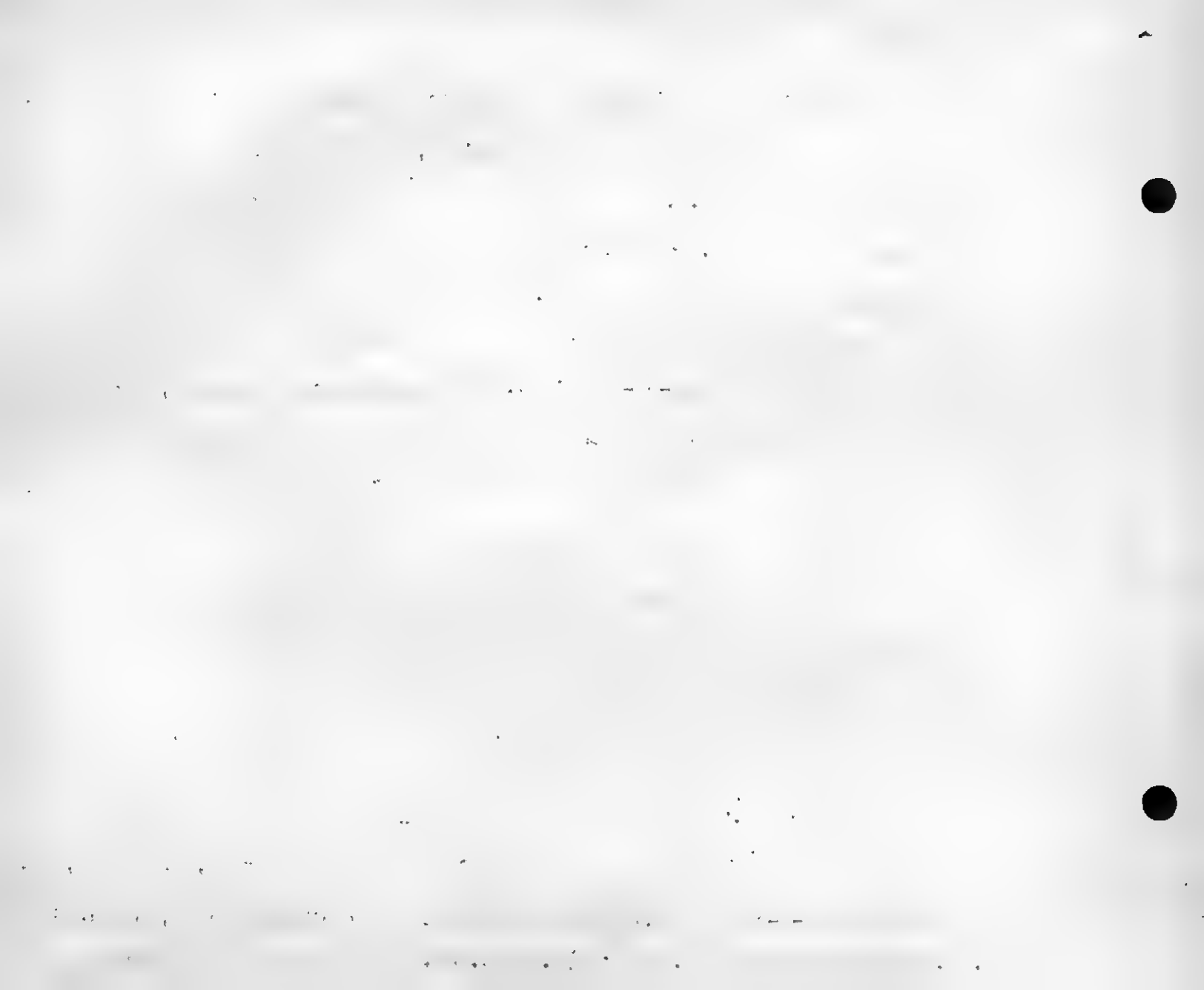
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05382

| | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|---|--|
| 1 DECEASED-NAME (Type or print) John William Burdette | | First John | | Middle William | | Last Burdette | | 2a. DATE OF DEATH April Month 7 Day 1969 Year | | | | 2b. HOUR 8 a. M. | |
| 3 SEX Male | | 4. RACE White | | | | 5. DATE OF BIRTH July 4, 1895 | | | | 6. AGE (In years last birthday) 73 YRS | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 COUNTY OF DEATH Frederick Md. | | | | | |
| 10 CITY OR TOWN OF DEATH Frederick | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Md. Odd Fellows Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Mt. Airy | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| 14 FATHER'S NAME First Middle Last George Henry Burdette | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Watkins | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes | | | | 16b. SOCIAL SECURITY NO. 212-32-4933 A | | 17. INFORMANT Address Md. Odd Fellows Home Frederick, Maryland | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 10 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1968 to April 7, 1969 , that (I) (we) last saw the deceased alive on April 6, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE B.O. Thomas Jr. M.D. | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED April 7, 1969 | |
| 22d. PHYSICIAN'S NAME (Type) B.O. Thomas Jr. | | | | 22e. ADDRESS 228 North Market Street, Frederick, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4-9-69 | | 23c. NAME OF CEMETERY OR CREMATORY Montgomery Chapel Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Claggettville, Maryland | | | | | |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son 106 E. Church St. Fred. Md. | | | | 25a. REC'D BY REGISTRAR APR 10 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--------------------------------|---|--------------------------|----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | First | | Middle | | Last | | 2a DATE OF DEATH | | | 2b HOUR |
| Douglas | | Samuel | | Castle | | April | | | Month 27 Day 69 Year | | 3:10 M |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (in years last birthday) | | 7 UNDER YEAR MONTHS DAYS | | 8 UNDER 24 HRS HOURS M.N. |
| Male | | White | | Dec. 25- 1883 | | | 85 YRS | | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | | | Frederick | | | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Frederick | | | | Frederick Mem. Hospital | | | | Farming- Retired | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| Md. | | Frederick | | Jefferson | | | | | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | |
| Abraham P. Castle | | | | Jane Rebecca DeGrange | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | | | |
| No | | 220-30-9478 | | Russell S. Castle- Adamstown- Md. 21710 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> | | | | | | | | | | | 3 days |
| 4567 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1948, to 4/27, 1969, that (I) (we) last saw the deceased alive on 4/26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | | |
| James B. Thomas, MD. | | | | | | Apr. 27-1969 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| James B. Thomas | | | | | | Prof. Bldg.-Frederick, Md. 21701 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | Apr. 30-1969 | | Mt. Olivet Cemetery | | Frederick, Md. 21701 | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| M.R. Etchison & Son | | | | | | MAY 1 1969 | | Charles Judge | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05391

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05384

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--------|--|-----------------------------------|---|--|--|---|
| 1 DECEASED NAME (Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4 11 1969 | | 2b HOUR M |
| WILLIAM | | E. | CLARK | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | 7 UNDER 1 YEAR MONTHS DAYS | 8 UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD Month 4 Day 11 Year 1969 | 2d HOUR 6 P M |
| Male | White | Feb. 22, 1900 | 69 YRS | | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Frederick Md | |
| Maryland | | U.S.A. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Rural-Mt. Airy | | Route 4 | | Farmer | | | |
| 13a USUAL RESIDENCE (Where deceased admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Frederick | | Mt. Airy | | Route 4 | |
| 14 FATHER'S NAME | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | First Middle Last |
| Philip | | | | Clark | Effie | | Snyder |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | |
| No | | 220-18-0169 | | Mrs. Helen R. Clark | | Same As #13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> | | | | | | | |
| 4122 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriolar Cardiovascular</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF. (c) <u>Disease</u> | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | Robert J. Thomas | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b DATE SIGNED 4-11-69 | |
| EXAMINER'S NAME (Type) | | Robert J. Thomas, M.D. | | ADDRESS (Street, city, town, or county) | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Burial | | 4/14/1969 | | Prospect Cemetery | | Frederick, Md. | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | 25a REC'D BY REGISTRAR DATE | |
| C. M. Waltz, Box 241, Sykesville, Md. | | | | | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

ROBERT J. THOMAS, M.D.
812 TOLL HOUSE AVENUE
FREDERICK, MARYLAND



TO HOSPITAL C. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

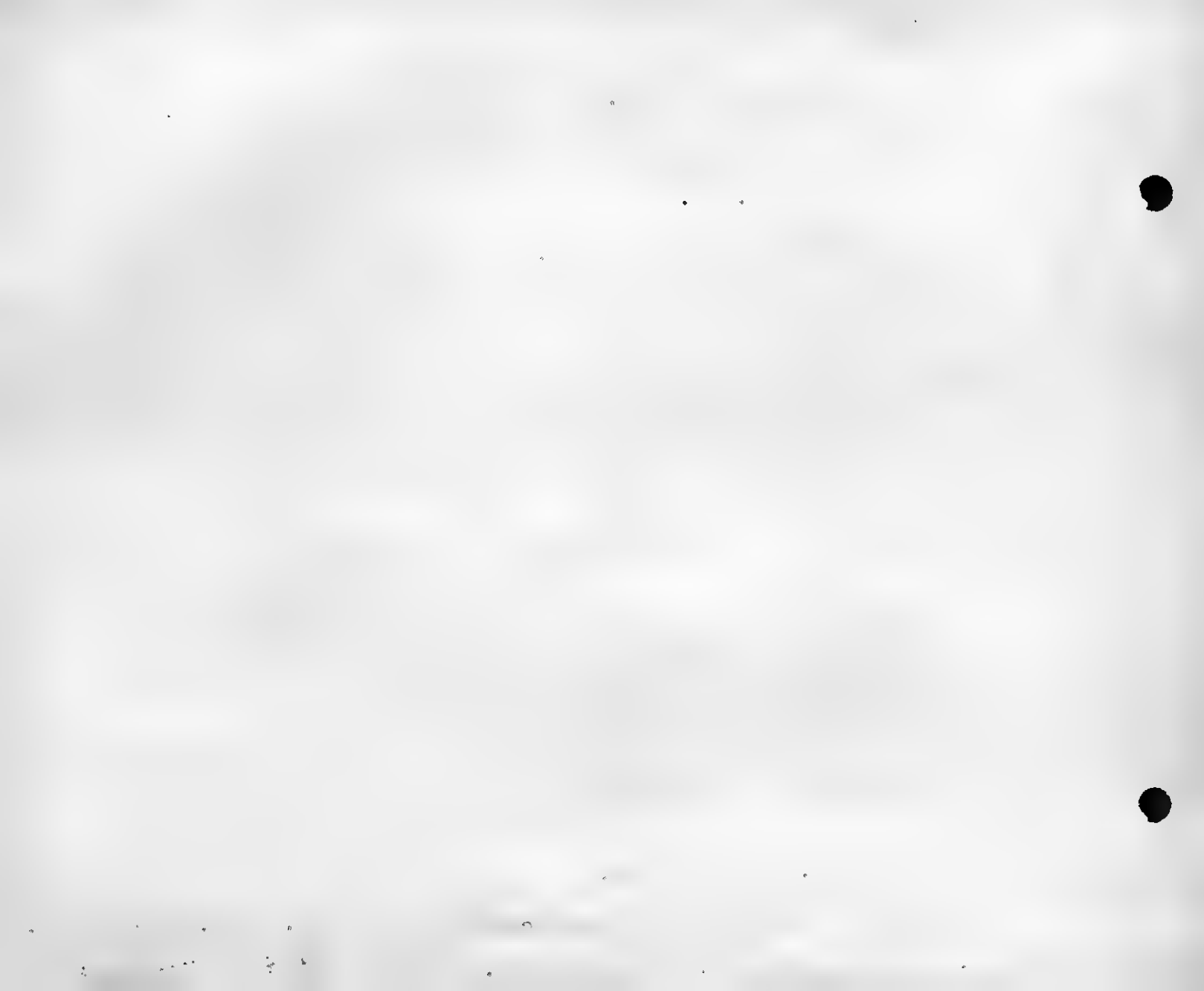
05392

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05385

| | | | | | | | | | |
|--|--|--|--------------|---|--|--|---|-----------------------------------|--|
| 1 DECEASED NAME (Type or print) | | First EUNICE | Middle E. | Last CLARY | 2a. DATE OF DEATH Month Day Year April 7, 1969 | | 2b. HOUR 5:45 A.M. | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH April 15, 1891 | | 6. AGE (In years last birthday) 77 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Frederick Md. | | | |
| 10 CITY OR TOWN OF DEATH Frederick | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Howard | | 13c CITY OR TOWN Lisbon | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| 14 FATHER'S NAME First Middle Last Walter Warfield | | 15 MOTHER'S MAIDEN NAME First Middle Last Frances Day | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO | | 16b SOCIAL SECURITY NO (If yes give war or dates of service) 217-16-2154 | | 17 INFORMANT N. Monroe Clary | | Address Same As #13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>UREMIA</u> | | | | | | | | | 10 weeks |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) <u>ANURIA</u> | | | | | | | | | 1 week |
| (c) <u>Adenocarcinoma of colon & blockage of ureters</u> | | | | | | | | | 1 year |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3 April</u> , 19 <u>69</u> , to <u>7 April</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6 April</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <u>G. I. Smith, Jr.</u> | | DEGREE PHYS | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS | | 22c. DATE SIGNED 7 Apr 69 | | | |
| 22d PHYSICIAN'S NAME (Type) G. I. Smith, Jr. | | 22e ADDRESS | | | | | | | |
| 23a BURIAL, CREMATION, or other disposal (Specify) Burial | | 23b DATE 4/10/1969 | | 23c NAME OF CEMETERY OR CREMATORY Prospect Cemetery | | 23d LOCATION (City or Town) (County) (State) Frederick, Md. | | | |
| 24 FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md. | | | | 25a REC'D BY REGISTRAR APR 10 1969 | | 25b. REGISTRAR'S SIGNATURE <u>William J. Young</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| <div>05393</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>05386</div> | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|--------------------------|--|--|--------------|--|--|---------------|--|--|
| 1. DECEASED-NAME (Type or print) | | | First JOHN | | | Middle HENRY | | | Last CLINE | | | 2a. DATE OF DEATH Month April | | | Day 24 | | | Year 1969 | | | 2b. HOUR M | | |
| 3 SEX male | | | 4 RACE caus. | | | 5 DATE OF BIRTH May 19, 1889 | | | 6 AGE (In years last birthday) 79 YRS. | | | IF UNDER 1 YEAR MONTHS | | | IF UNDER 24 HRS HOURS | | | MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Frederick Md | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Rural-Myersville | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Rt. # 1 | | | 12a. US. JAC. OCCUPAT. ON (Kind of work done during most of working life, even if retired) Farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY own gen. fram | | | | | | | | | | | | | | |
| 13a. US. JAC. RESIDENCE (Where deceased lived, if institution admission) STATE Maryland | | | 13b. COUNTY Frederick | | | 13c. CITY OR TOWN Myersville | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER Route # 1 | | | | | | | | | | | |
| 14 FATHER'S NAME First J. | | | Middle Wesley | | | Last Cline | | | 15 MOTHER'S MAIDEN NAME First Laura | | | Middle Schildtknecht | | | Last Cline | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO (If yes give war or dates of service) 215-36-7170 | | | 17 INFORMANT Address Mrs. Naomi Harne, Myersville, Md. | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Coronary occlusion, acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>15 yrs.</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or RFD No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1969, to <u>Mar 24</u> , 1969, that (I) (we) last saw the deceased alive on <u>March 25</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>R.S. Stauffer</u> | | | 22c. DATE SIGNED <u>Apr. 25, 1969</u> | | | 22d. PHYSICIAN'S NAME (Type) R.S. STAUFFER | | | 22e. ADDRESS <u>Hagerstown, Md.</u> | | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE <u>April 26, 1969</u> | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion U. Methodist, Myersville, Fred. Co. Md.</u> | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR <u>Paul F. Bittle</u> | | | 24b. ADDRESS <u>Myersville, Md.</u> | | | 25a. RECD BY REGISTRAR DATE <u>APR 28 1969</u> | | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 05394 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 05387 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First John Middle ADOLPHUS Last COOKERLY | | | | | | | | | | Month APR Day 22 Year 69 | | | | | | | | | | 7:50P M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | | | | | | | | | 4. RACE Caucasian | | | | | | | | | | 5. DATE OF BIRTH June 4, 1893 | | | | | | | | | | 6. AGE (In years last birthday) 75 YRS | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Frederick, Md. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Frederick, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Retired Laborer | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | | | | | | 13b. COUNTY Frederick | | | | | | | | | | 13c. CITY OR TOWN Frederick | | | | | | | | | | 13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER Butterfly Lane | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First George Middle Cookerly Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Molly Middle Eichley Last | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No | | | | | | | | | | 16b. SOCIAL SECURITY NO 214-10-5672 | | | | | | | | | | 17. INFORMANT Mrs. John A. Cookerly, Sr. Rt. #4 Frederick, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) AC. Congestive Heart Failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4125 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia | | | | | | | | | | 1 day | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) Advanced atherosclerotic Heart Disease | | | | | | | | | | 10-15 yrs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965, to APR 22, 1969, that (I) (we) last saw the deceased alive on APR 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Ralph L. Michels M.D. | | | | | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED APR. 22, 69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Ralph L. Michels, M.D. | | | | | | | | | | 22e. ADDRESS Frederick, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 4-25-1969 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Frederick, Frederick, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Robert E. Darley & Son | | | | | | | | | | ADDRESS Frederick, Md. | | | | | | | | | | 25a. RECEIVED BY REGISTRAR DATE APR 25 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05395

CERTIFICATE OF DEATH

05388

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) ELIZABETH | | | First Middle Last B. DELAUDER | | | 2a. DATE OF DEATH April Month 24 Day 1969 | | | 2b. HOUR 8:15 P.M. | | |
| 3. SEX Female | | | 4. RACE Caucasian | | | 5. DATE OF BIRTH May 27, 1908 | | | 6. AGE (In years lost birthday) 60 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Frederick, Md. | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Frederick | | | 13c. CITY OR TOWN Frederick | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME Joseph | | | First Middle Last Himes | | | 15. MOTHER'S MAIDEN NAME Bertha | | | First Middle Last Himes Everhart | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO 219-12-2054 | | | 17. INFORMANT Address Fred. Md. Mr. David D. Delauder 500 Military Rd. | | | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous Primary of breast DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from August , 19 67 , to April 24 , 19 69 , that (1) (we) lost the deceased alive on April 23 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE W J Riddick | | | M.D. DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 4/24/69 | | |
| 22d. PHYSICIAN'S NAME (Type) Willis J. Riddick | | | M.D. | | | 22e. ADDRESS Frederick Medical Center Frederick, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 4-28-1969 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Petersville, Frederick, Md. | | |
| 24. FUNERAL DIRECTOR Robert E. Dailey & Son | | | ADDRESS Frederick, Md. | | | 25a. REC'D BY REGISTRAR APR 28 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05396

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05389

| | | | | | | | | | |
|---|--------|--|------------------|---|-------------------------------------|--|---|--|--|
| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | | |
| Mary Virginia Delauter | | | | | April 2 1969 | | 6:05 PM | | |
| 3 SEX | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| Female | White | | April 25, 1966 | | 62 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Frederick Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Frederick | | Frederick Mem. Hosp. | | Housewife | | Own home | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Frederick | | Middletown | | | | Hawbottom Rd. R.F.D. 2 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| Walter F. Lewis | | Sally Virginia Adkins | | No | | None | | Lorraine Wolf--R.F.D. 2 Middletown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchitis & Bunchopneumonia</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 25, 1969</u> , to <u>April 2, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 2, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Gilcin F. Meadors M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>3 April 69</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Gilcin F. Meadors M.D.</u> | | | | 22e. ADDRESS <u>810 Toll House Ave. Fred. Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | April 5, 69 | | Grossnickle Cemetery | | Ellerton Fred. Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Gladhill Company Middletown, Md. | | | | DATE <u>APR 7 1969</u> | | <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--------|--|---|---|---|--|--|-----------------------------------|------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| John Howard Leroy Despeaux | | | | | April Month 12 Day 1969 Year | | | 6:03 M | |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | White | | Nov. 14-1914 | | 54 YRS | | MONTHS DAYS | | HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md. | | U. S. A. | | | | Frederick Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Frederick | | | Frederick Mem. Hospital | | | Machinist | | Govt. Ft. Detrick | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Md. | | | Frederick | | Frederick | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 219 Thomas Avenue |
| 14 FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Frank Despeaux H. Despeaux | | | Nannie Sophia Shankle | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | | | |
| No | | | 220-05-6052 | | Frederick Address Md. 21701 Mrs. Virginia L. Despeaux-219 Thomas Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | |
| PART I DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Carcinoma, Colon</u> | | | | | | | | | |
| 1538 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 17, 1963, to Apr 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Thomas E Stone | | | | | | | | Apr. 12-1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| Thomas STONE | | | | Frederick Md | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Apr. 15-1969 | | Mt. Olivet Cemetery | | Frederick-Md. 21701 | | | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| M.R. Etchison & Son | | | | Whitmore Frederick-Md. 21701 | | APR 15 1969 | | V. L. Under | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

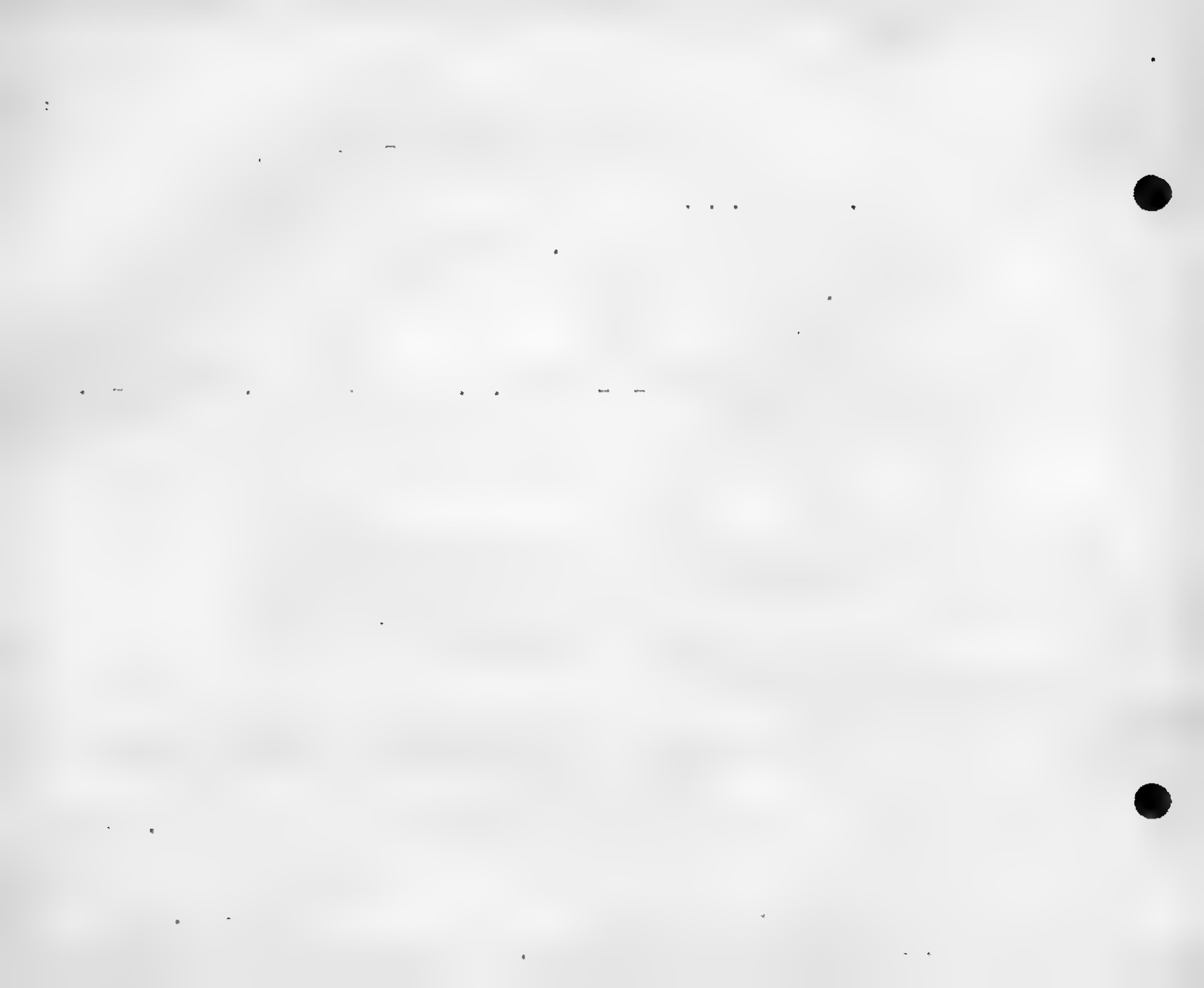
| 05398 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 05391 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Richard Lee DUTROW | | | | | | | | | | Month APR Day 18 Year 69 | | | | | | | | | | 10:20 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | | | | | | | | | 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH JULY 17 th , 1885 | | | | | | | | | | 6. AGE (In years last birthday) 83 YRS. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Frederick Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nursing Home | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - R.R. | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | | | | | | | 13b. COUNTY Frederick | | | | | | | | | | 13c. CITY OR TOWN Adamstown | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| 14. FATHER'S NAME First R. Middle Claude Last Dutrow | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Ida Middle Beck Last | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO 705-09-1088 | | | | | | | | | | 17. INFORMANT Frederick Address Md. 21701 R. Ormond Dutrow-620 Fairview Ave. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Broncho pneumonia | | | | | | | | | | 10 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) Anemia, of undetermined origin | | | | | | | | | | 4 yrs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cerebral arterio sclerosis. Arterio sclerotic heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | | | | | | | | 21c. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to APR 18, 1969, that (I) (we) lost saw the deceased alive on APR 11 th , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Ralph L. Michels, M.D. | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED APR 18 th , 69 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Ralph L. Michels | | | | | | | | | | 22e. ADDRESS Frederick Medical Center-Frederick, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE Apr. 21-1969 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Frederick, Frederick, Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR M.R. Etchison & Son | | | | | | | | | | ADDRESS Frederick, Md. 21701 | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE APR 21 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-14-69
45M 169

| MAY 1 1969 | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|---|-------|
| <div style="display: flex; justify-content: space-between;"> 05399 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05399 </div> | | | | | | | | | | |
| 1. DECEASED NAME <u>Lettie First Olivia</u> Middle <u>Ferrell</u> Last <u>Ferrell</u> | | | | | | 2a. DATE OF DEATH <u>April</u> Month <u>28</u> Day <u>69</u> Year | | 2b. HOUR <u>4:30</u> MIN <u>M</u> | | |
| 3 SEX <u>Female</u> | | 4 RACE <u>White</u> | | 5. DATE OF BIRTH <u>March 23-1891</u> | | 6 AGE (In years last birthday) <u>78</u> YRS | | IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Frederick</u> | | | | |
| 10. CITY OR TOWN OF DEATH <u>Frederick</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Frederick Mem. Hospital</u> | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <u>Home maker</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 13a. USUA. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <u>Md.</u> | | | 13b. COUNTY <u>Frederick</u> | | 13c. CITY OR TOWN <u>Brunswick</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>217 A Street</u> | |
| 14 FATHER'S NAME First <u>Josiah</u> Middle <u> </u> Last <u>Gross</u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Alice</u> Middle <u> </u> Last <u>Castle</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u> (If yes give war or dates at service) | | | 16b. SOCIAL SECURITY NO <u>218-30-8924B</u> | | 17 INFORMANT Address <u>Wm. D. Ferrell-217 A St.-Brunswick-Md.21716</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u> <u>4 hrs</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cholelithiasis</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home farm street, factory office building etc.) | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>4/28</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>A. Talbot Birge</u> | | | | | | 22c. DATE SIGNED <u>Apr. 28-1969</u> | | 22d. PHYSICIAN'S NAME (Type) <u>A. Talbot Birge</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE <u>May 1-1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Jefferson- Md. 21755</u> | | 25a. BY REGISTRAR <u>May 1 1969</u> | |
| 24. FUNERAL DIRECTOR <u>W.L.R. Etchison & Son</u> | | | | | | ADDRESS <u>Frederick, Md. 21701</u> | | 25b. REGISTRAR'S SIGNATURE <u>William Judge</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

| 1. DECEASED NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR |
|--|--|---|--------|---|-------------------|--|----------|
| ELMER | | | WILSON | FISHER | April | 17 | 11:38 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| Male | | White | | November 5, 1901 | | 67 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Maryland | | U. S. A. | | | | Frederick | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Frederick | | Frederick Memorial Hospital | | Eng. Dept. Supervisor | | Md. School for Deaf | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Frederick | | Frederick | | 13 East 13th. Street | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | |
| George | | Elmer Fisher | | Catherine M. Stottlemeyer | | 214 10 1311 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| Mrs. Johano Fisher, 13 E. 13th. St. | | PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute anterior myocardial infarction</u> 2 days DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> 5 years DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>62</u> to <u>April 17</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>April 17</u> , 19 <u>69</u> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>LeRoy T. Davis</u> | | 22c. DATE SIGNED <u>4/17/69</u> | | 22d. PHYSICIAN'S NAME (Type) <u>LeRoy T. Davis, M.D.</u> | |
| 22e. ADDRESS <u>228 N. Market Street, Frederick, Md.</u> | | 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | Burial | | April 19, 1969 | | Frederick Memorial Park | |
| 24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Md.</u> | | 25a. REC'D BY REGISTRAR <u>APR 21 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 25c. LOCATION (City or Town) (County) (State) Frederick Frederick Md. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05401

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05394

| | | | | | | | | | | | | |
|--|--|---|---|---|---|---|--|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Bessie Estella Forrest | | | 2a. DATE OF DEATH Month 4 Day 12 Year 69 | | | 2b. HOUR M | | | | | | |
| 3 SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 12/6/03 | | 6. AGE (in years) 65 (birthday) | | 7. IF UNDER 1 YEAR MONTHS YRS. DAYS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | | | Md | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) Frederick Memorial | | | 12a. U.S.A. OCCUPATION (Kind of work done during last week, even if retired.) housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Frederick | | | 13c. CITY OR TOWN Brunswick | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET AND NUMBER 819 E. Potomac St. | | | 14. FATHER'S NAME First James Middle Dillow Last Dillow | | | 15. MOTHER'S MAIDEN NAME First Martha Middle Cage Last Cage | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes, give war or dates of service) | | | 16b. SOCIAL SECURITY NO. none | | | 17. INFORMANT Donald E. Forrest- Frederick, Md. | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) ULCERATION OF STOMACH | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAR. 24, 1969 , to APRIL 11, 1969 , that (I) last saw the deceased alive on APRIL 10, 1969 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) had (did) not view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE G. F. Meadows | | | DEGREE G.F. MEADORS MD | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED 4/14/69 | | | |
| 22d. PHYSICIAN'S NAME (Type) G.F. MEADORS MD | | | 22e. ADDRESS 810 TOLHOUSE AVE FREDERICK MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 4/15/69 | | | 23c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery Brunswick, Md. | | | 23d. LOCATION (City or Town) (County) (State) Frederick, Md. | | | |
| 24. FUNERAL DIRECTOR Feet's Funeral Home | | | 25a. REC'D BY REGISTRAR APR 15 1969 | | | 25b. REGISTRAR'S SIGNATURE William J. Judge | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
45M - 1969

05402

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05395

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|---|---|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last SCOTT Y. GARNER | | | 2a. DATE OF DEATH Month Day Year April 7 1969 | | | 2b. HOUR 1:10 P | | | | | |
| 3 SEX Male | | 4. RACE Caucasion | | 5. DATE OF BIRTH June 22, 1886 | | 6 AGE (In years last birthday) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 9 16 | | IF UNDER 24 HRS. HOURS MIN 16 | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Frederick | | |
| 10 CITY OR TOWN OF DEATH Frederick | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Nursing Center | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER AND CARPENTER | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Corroll | | | 13c CITY OR TOWN Westminster | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 123 E. Green Street | |
| 14 FATHER'S NAME First Middle Last JASPER GARNER | | | 15 MOTHER'S MAIDEN NAME First Middle Last HANNAH YON | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | | 16b SOCIAL SECURITY NO 215-26-8258-A | | | 17. INFORMANT MRS EDITH R. GARNER | | | Address 123 East Green St Westminster, Md | | |
| 1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism 4: DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial insufficiency Cond. tions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension | | | | | | | | | | | |
| 19a DATE OF OPERATION Apr 7 1969 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3 Apr 1969 to 7 Apr 1969 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE James E. Crosby, M.D. | | | | | | DEGREE M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED Apr 7, 1969 | |
| 22d PHYSICIAN'S NAME (Type) James E. Crosby, M.D. | | | | | | 22e ADDRESS 700 Montclair Avenue - Frederick | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b DATE 4/10/69 | | 23c NAME OF CEMETERY OR CREMATORY MEDDON BRANCH CEMETERY RURAL, WESTMINSTER, MD. | | | 23d LOCATION (City or Town) (County) (State) WESTMINSTER, MD. | | | |
| 24 FUNERAL DIRECTOR L. S. Smyer Jr., Westminster, Md. | | | | | | ADDRESS | | 25a REC'D BY REGISTRAR APR 10 1969 | | 25b REGISTRAR'S SIGNATURE Olemla Judge | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 05403 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05396 | |
| 1. DECEASED-NAME (Type or print) Columbus | | Middle D. | | Last Gordon | | 2a. DATE OF DEATH Month 4 Day 11 Year 69 | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH 8/3/98 | | 6. AGE (In years last birthday) 70 YRS. MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | |
| 10. CITY OR TOWN OF DEATH Burkittsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) residence | | 12a. USUAL OCCUPATION (Kind of work done during life, even if retired) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Burkittsville | | 13d. STREET AND NUMBER Rural | |
| 14. FATHER'S NAME First George Middle Gordon Last Gordon | | 15. MOTHER'S MAIDEN NAME First Charity Middle Morris Last Morris | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 212-20-6828A | | 17. INFORMANT Mrs. Sarah J. Gordon-Burkittsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4104 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 54 min | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Coronary Arteriosclerosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/4 , 19 67 , to 11/11 , 19 67 , that (I) (we) last saw the deceased alive on 7/9 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Ed. J. Bruce M.D. | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) A. T. BRIKE | | 22e. ADDRESS Petersville, Md. | |
| 23a. BURIAL, CREMATION, REMOVING (Specify) | | 23b. DATE 4/15/69 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 23d. LOCATION (City or Town) Petersville (County) Fred. (State) Md. | |
| 24. FUNERAL DIRECTOR Feete Funeral Home Brunswick, Md. | | 25a. REC'D BY REGISTRAR APR 15 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4107

05404

CERTIFICATE OF DEATH

05397

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) THOMAS WILLIAM Griffith | | | 2a. DATE OF DEATH 4 Month 28 Day 69 Year | | 2b. HOUR 7:34 M |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH APRIL 26 - 1905 | | 6. AGE (In years last birthday) 64 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) W. VA. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH FREDERICK Md. | | |
| 10. CITY OR TOWN OF DEATH RURAL NEW WINDSOR | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SAMS CREEK | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER EMPLOYEE | 12b. KIND OF BUSINESS OR INDUSTRY FARM | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND | 13b. COUNTY FREDERICK | 13c. CITY OR TOWN NEW WINDSOR | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER SAMS CREEK | |
| 14. FATHER'S NAME First EMANUEL Middle GRIFFITH Last GRIFFITH | | 15. MOTHER'S MAIDEN NAME First Laura Middle SUMMERS Last SUMMERS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 215-32-2675 | 17. INFORMANT MERTON ENGEL Address RURAL NEW WINDSOR MD | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 41-7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dilated Myocardium | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/16 , 19 66 , to 3/3 , 19 69 , that (I) (we) last saw the deceased alive on 3/3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Julius Chepko | | DEGREE ATTENDING PHYS | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | 22c. DATE SIGNED 4/28/69 | |
| 22d. PHYSICIAN'S NAME (Type) JULIUS CHEPKO | | 22e. ADDRESS WESTMINSTER MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE MAY 1 - 1969 | 23c. NAME OF CEMETERY OR CREMATORY PIPE CREEK | 23d. LOCATION (City or Town) (County) (State) NEW WINDSOR RURAL MD | | |
| 24. FUNERAL DIRECTOR D D Hartzler & Sons New Windsor | | 25a. REC'D BY REGISTRAR MAY 1 1969 | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



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VR A15
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|------|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| Charles Alfred Harner | | | | | | April 12, 1969 | | | 12:00 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| Male | | White | | March 20, 1893 | | 76 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Carroll Co. Md. | | U.S.A. | | | | Frederick Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Emmitsburg, | | | Center Square | | | Ret. Business Man | | Store | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Frederick | | | Emmitsburg | | Center Square | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | |
| Harry Harner | | | | | | Carrie Forney | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | |
| | | | 217-32-5030 | | | Mrs. Edith S. Harner, Emmitsburg, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>41</u> <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sudden death</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | June 30, 1969 to Sept 12, 1969 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1969</u> to <u>Sept 12, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>W. R. Cadle</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>12/9/69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. W. R. Cadle | | | | 22e. ADDRESS Emmitsburg, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | April 14, 1969 | | Keysville Cemetery | | Keysville, Carroll Co. Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Clarence E. Wilson | | APR 16 1969 | | Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | | | | | | |
|---|--|---|--------|--|--|---|--|------------------------------|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| JOSHUA JACKSON HENRY | | | | | April 16 1969 | | 45 PM | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| Male | Colored | 12-7-1888 | | | 80 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| New Jersey | U.S.A. | | | Frederick | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | Frederick Memorial Hosp | | | Hotel Waiter | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution) | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | |
| Md | Frederick | Frederick | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1 South Bentz Street | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle |
| Jackson NMN | | | | Henry | Margretta NMN | | | Thornton |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | |
| No | | 217-10-2511 | | Mrs Louise Henry | | 22 South Court Street | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure | | | | | | | | |
| 11-3 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) Arterio-sclerotic heart dis. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| Atherosclerosis | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/5/69, 19, to 4/16/69, 19, that (I) (we) last saw the deceased alive on 4/16/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED |
| Charles H. Conley, Jr MD | | | | | | | | 16 April 1969 |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | |
| Charles H. Conley, Jr Md | | | | Professional Bldg Frederick, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 4-19-1969 | | Fairview | | Frederick Frederick Md | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| C.E. Hicks, 111 Frederick, Md | | | | | | APR 21 1969 | | W. Charles Vande... |



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VR A15
45M

| 05407 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05400 | | |
|---|--|--|---|--|-----------------------------|---|--|----------------------------------|
| 1 DECEASED NAME (Type or print) | | | First | Middle | Last | 2a DATE OF DEATH Month Day Year | | 2b HOUR |
| Tissie | | | Kate | | Hooper | April 12 1969 | | 12:50 PM |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR MONTHS DAYS |
| Female | | White | | Oct. 22, 1881 | | 87 YRS | | 1 UNDER 24 HRS HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Maryland | | U.S.A. | | | | Frederick Md | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY |
| Frederick | | | Frederick Mem. Hosp. | | | Housewife | | Own home |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | 13d INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER |
| Maryland | | | Frederick | | Middletown | | | Green St. |
| 14 FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Lewis Caswell Shank | | | Susan Elizabeth Haupt | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | 17. INFORMANT Address | | | |
| No (unknown) | | | 217-56-0604 | | Louis Ahalt Middletown, Md. | | | |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>aspiration</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>duodenal obstruction + intestinal bleeding</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>duodenal ulcer or carcinoma of pancreas</u> | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive heart failure 2° to arteriosclerotic cardiac vascular disease</u> | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or RFD No City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12 April, 1969</u> , to <u>12 April, 1969</u> , that (I) (we) last saw the deceased alive on <u>12 April, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b SIGNATURE | | 22c DEGREE | | 22d ADDRESS | | 22e DATE SIGNED | | |
| George L. Smith Jr. | | M.D. | | 804 TollHouse Ave. Frederick, Md. | | 12 April 69 | | |
| 22d PHYSICIAN'S NAME (Type) | | 22e ADDRESS | | | | | | |
| George L. Smith Jr. M.D. | | | | | | | | |
| 23a BURIAL, CREMATION, OR DISPOSITION | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | |
| Burial | | April 15, 1969 | | Fred. Mem. Park | | Frederick Fred. Md. | | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a RECD BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Gladhill Co. | | Middletown, Md. | | APR 15 1969 | | Thomas Jones | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

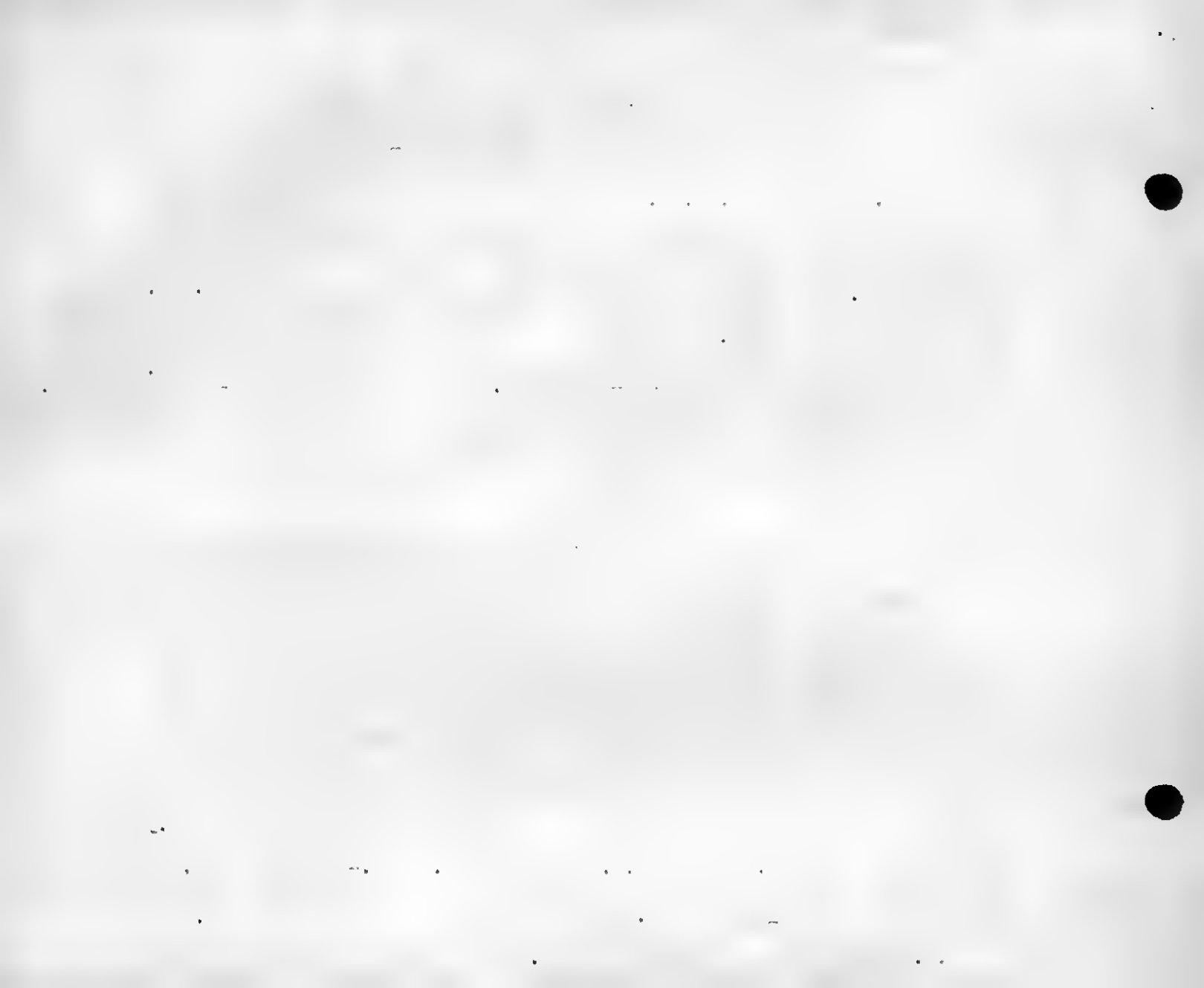
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|--|---|--|--|---|------------------------------|--|
| 05408 | | | | | CERTIFICATE OF DEATH | | | | | 05401 | | | | | |
| 1 DECEASED NAME (Type or print) First Middle Last Florence Elizabeth Horseman | | | | | 2a. DATE OF DEATH Month Day Year April 15 1969 | | | | | 2b. HOUR 11 p.m. | | | | | |
| 3. SEX Female | | | 4 RACE White | | | 5 DATE OF BIRTH April 23, 1903 | | | 6 AGE (n years last birthday) 65 YRS. | | | F UNDER 1 YEAR MONTHS DAYS | | F UNDER 24 HRS. HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Frederick Md | | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hosp. | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b KIND OF BUSINESS OR INDUSTRY Own home | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution) STATE Maryland | | | 13b COUNTY Frederick | | | 13c CITY OR TOWN Middletown | | | 13d WAS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET AND NUMBER Hawbottom Rd. R.D.2 | | | |
| 14. FATHER'S NAME First Middle Last Joseph Volluse | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Annie Unglebower | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | 16b SOCIAL SECURITY NO. ----- | | | 17 INFORMANT Calvert J. Horseman | | | Address Route #2 Middletown, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolus, massive</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral thrombophlebitis deep</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>femoral veins</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia Bronchial asthma</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>1 wh</u> | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1969</u> , to <u>April 15, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death | | | | | | | | | | 22c DATE SIGNED 16 April 69 | | | | | |
| 22b SIGNATURE Henry V. Chase | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) Henry V. Chase | | | | | 22e ADDRESS 804 Toll House Frederick Md | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b DATE April 18, 69 | | | 23c NAME OF CEMETERY OR CREMATORY Harmony Cemetery | | | 23d LOCATION (City or Town) (County) (State) Myersville Fred. Md. | | | | | | |
| 24 FUNERAL DIRECTOR Gladhill Company | | | | | ADDRESS Middletown, Md. | | | | | 25a REC'D BY REGISTRAR DATE APR 21 1969 | | | 25b REGISTRAR'S SIGNATURE V. C. Jones, Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 14
ISM 1/69

| 05409 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 05409 | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|---------------------------|--|--|--|--|
| 1 DECEASED NAME (Type or print) | | | | | | | | | | 2a DATE OF DEATH | | | | | | | | | | 2b HOUR | | | | | | | | | |
| First Middle Last Claude Franklin Humm | | | | | | | | | | April Month 29 Day 69 Year | | | | | | | | | | 9:10 M | | | | | | | | | |
| 3 SEX | | | | | 4 RACE | | | | | 5 DATE OF BIRTH | | | | | 6 AGE (In years last birthday) | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS HOURS MIN | | | | |
| Male | | | | | White | | | | | August 21- 1888 | | | | | 80 YRS. | | | | | | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9 COUNTY OF DEATH | | | | | | | | | | | | | | |
| Md. | | | | | U. S. A. | | | | | | | | | | Frederick Md | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Frederick | | | | | Frederick Nursing Home | | | | | Retired- | | | | | Farming | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | | 13b COUNTY | | | | | 13c CITY OR TOWN | | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e STREET AND NUMBER | | | | | | | | | |
| Md. | | | | | Frederick | | | | | Frederick | | | | | | | | | | 8 West 4th. St. | | | | | | | | | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last John Wm. Humm | | | | | First Middle Last Clara Mainhart | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b SOCIAL SECURITY NO. | | | | | 17 INFORMANT | | | | | | | | | | | | | | | | | | | |
| No | | | | | 212-14-7669A | | | | | Baltimore address Md. 21212 Mrs. Catherine Humm Wooden-323 Hopkins Rd. | | | | | | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic arteriosclerosis</u> 4109 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Chronic arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>3 years</u> <u>5 years</u> | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f LOCATION Street or RFD No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>63</u> , to <u>4/24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | 22c DATE SIGNED Apr. 30-1969 | | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e ADDRESS | | | | | | | | | | | | | | | | | | | |
| James B. Thomas- M.D. | | | | | | | | | | Prof. Bldg.-Frederick, Md. 21701 | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b DATE | | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | May 2-1969 | | | | | Mt. Olivet Cemetery | | | | | Frederick- Md. 21701 | | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | | 25a REC'D BY REGISTRAR | | | | | | | | | | 25b REGISTRAR'S SIGNATURE | | | | | | | | | |
| M.R. Etchison & Son | | | | | | | | | | Frederick, Md. 21701 | | | | | | | | | | MAY 5 1969 | | | | | | | | | |



05410

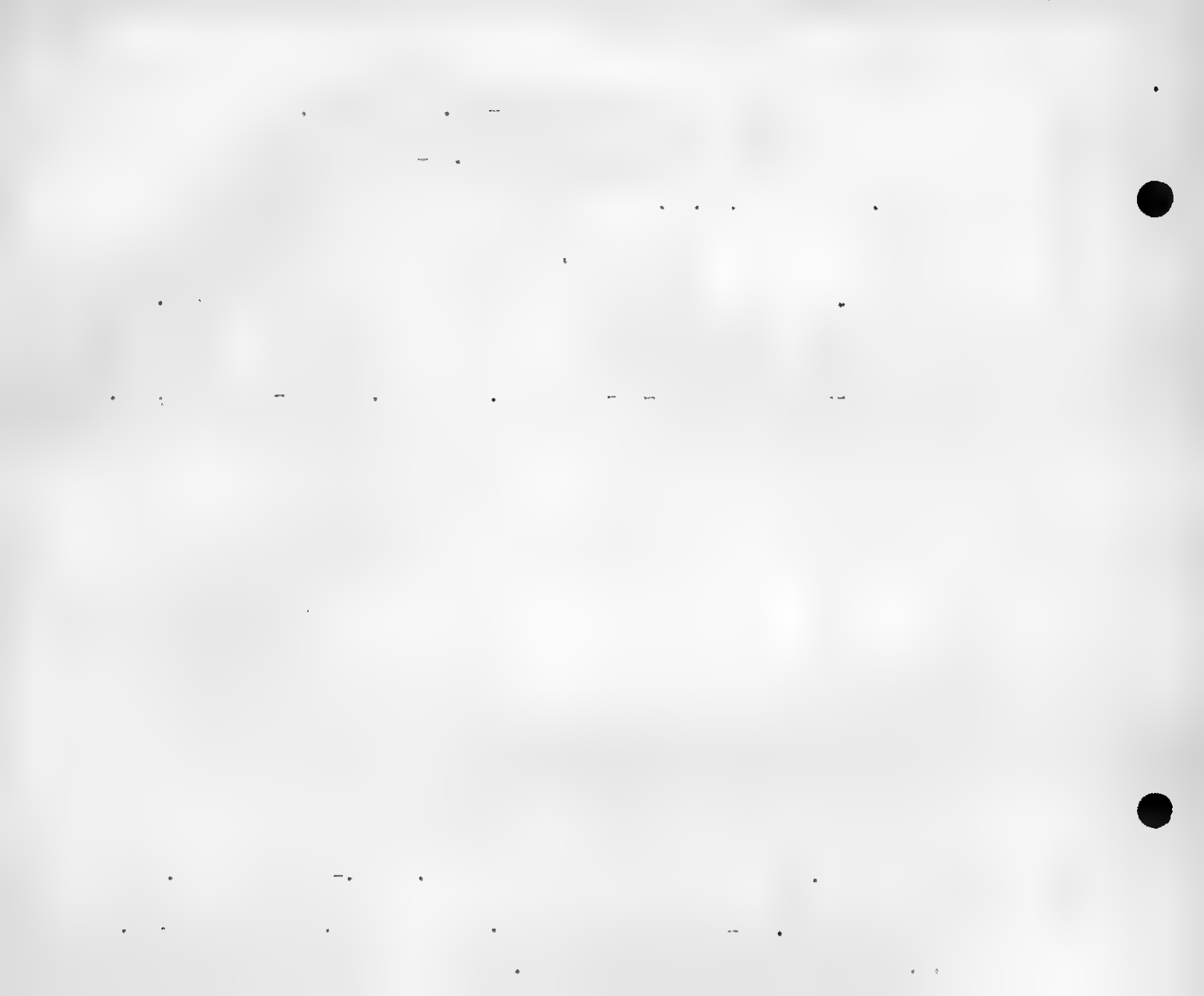
CERTIFICATE OF DEATH

05403

| | | | | | | | | | |
|---|--------|---|---|---|---|---|---|---|--|
| 1 DECEASED NAME (Type or print) | | First | Middle | Last | 2a DATE OF DEATH | | 2b HOUR | | |
| Clarence Edward Jewell- Sr. | | | | | Apr. Month 13 Day 69 Year | | 6:12 M | | |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER YEAR | | |
| Male | White | | Feb. 7-1895 | | 74 YRS | | MONTHS DAYS HOURS M N | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Va. | | U. S. A. | | | | Frederick Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | | Frederick Mem. Hospital | | Shovel Operator | | Construction | | |
| 13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| Md. | | Frederick | | Lime Kiln | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Lime Kiln-Md.21763 | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| John Henry Jewell | | | Maude Mason | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | |
| No | | 217-10-9905 | | Mrs. Bessie T. Jewell-Lime Kiln, Md. 21763 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> | | | | | | | | 1 week | |
| 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> | | | | | | | | 5 years | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18) | | | | | |
| 21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July, 1962, to April 13, 1969, that (I) (we) last saw the deceased alive on April 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <u>Dr. LeRoy T. Davis</u> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED 4/13/69 | | | |
| 22d PHYSICIAN'S NAME (Type) Dr. LeRoy T. Davis | | | | 22e ADDRESS Prof. Bldg.-Frederick, Md. 21701 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | Apr. 16-1969 | | Frederick Mem. Park | | W. of Frederick-Md.21701 | | | |
| 24 FUNERAL DIRECTOR <u>M.R. Etchison & Son</u> | | | | ADDRESS <u>Frederick, Md. 21701</u> | | 25a RECEIVED BY REGISTRAR DATE APR 15 1969 | | 25b REGISTER'S SIGNATURE <u>Robert A. Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

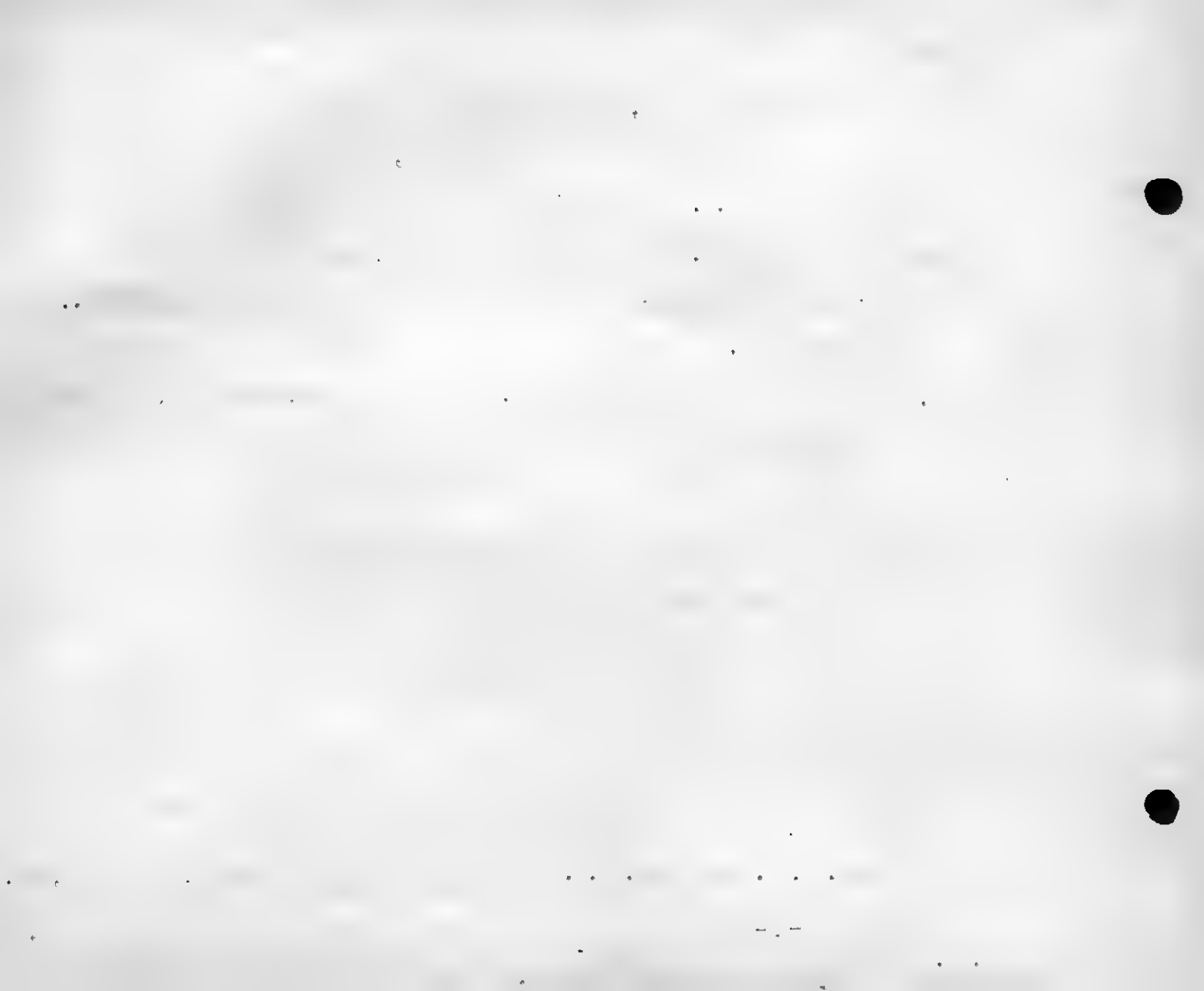
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--------|--|--|--------|------------------------------------|--|---|--|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 05411 | | | 05404 | | | | | | |
| DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| Agatha B. Johnston | | | | | | April 18 1969 | | | 11:30 a.m. |
| 3 SEX | 4 RACE | | 5. DATE OF BIRTH | | | 6. AGE (in years last birthday) | | 7. IF UNDER 1 YEAR | |
| Female | White | | January 9, 1885 | | | 84 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Maryland | | | U.S. | | | | | Frederick Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Frederick | | | Md. Odd Fellows Home | | | House wife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if not at on admission) STATE | | | 13c. CITY OR TOWN | | | 3d. INSIDE CITY, M.T.S.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Baltimore | | | | | 1401 South Charles St. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Christian P. Amendt | | | | | | Louisa Oberlander | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address |
| No. | | | 212-14-9083-11 | | | Md. Odd Fellows Home, Frederick, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arterio-sclerosis</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| | | | | | | | | | |
| MEDICAL CERTIFICATE | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1968</u> , to <u>April 18, 1969</u> , that (I) (we) lost saw the deceased alive on <u>April 18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE <u>B. O. Thomas Jr.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED <u>4/19/69</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. B. O. Thomas Jr. M.D.</u> 22e. ADDRESS <u>228 North Market Street, Frederick, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 4-23-69 | | Angel Hill Cemetery | | Havre de Grace Harford, Md. | | |
| 24. FUNERAL DIRECTOR <u>M. R. Etchison & Son Funeral Home</u> ADDRESS <u>106 East Church Street</u> 25a. REC'D BY REGISTRAR <u>APR 21 1969</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--------|------------------------------|--|---|---|--|---|---|---|
| <div>05412</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05405</div> | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| Rebecca | | | King | | | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 4 <input checked="" type="checkbox"/> 21 <input checked="" type="checkbox"/> 1969 | | | M |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| F | Cauc. | April 13, 1896 | 73 YRS | | | Month Day Year 4 21 1969 | | | M |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | Md |
| Virginia | | USA | | | | Frederick | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Frederick | | | Frederick Memorial | | | Nurse | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INS. OF CITY LIMITS? |
| D. C. | | | | | | Washington | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | |
| James Thomas Gray | | | Elizabeth Brown | | | 3420 16th St, Apt 202 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS |
| No | | | 577-32-9130 | | | Self | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED |
| <u>Robert J. Thomas</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | <u>22 APR 69</u> |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | April 25, 1969 | | Bethel Cemetery | | Alexandria Virginia | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Demaine Funeral Home Alexandria, Virginia | | | | | DATE APR 28 1969 | | <u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 05413 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05406 2:15 PM </div> | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME (Type or print) | | | | | | 2a. DATE OF DEATH | | | | | |
| William Marshall Leatherman | | | | | | Month 4 Day 21 Year 69 | | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | Oct. 27, 1912 | | 56 YRS | | MONTHS | | DAYS | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | Frederick Md | | | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | |
| Myersville | | | | R.F.D. | | | | Carpenter | | | |
| 13a USUAL RESIDENCE (Where deceased admission) STATE | | | | 13b CITY OR TOWN | | 13c INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | | |
| Maryland | | | | Frederick | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Route #2 Myersville Rd | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Floyd Leatherman | | | | Annie Flook | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO | | 17. INFORMANT | | | | | |
| No | | | | 220-30-6346 | | Mrs. Edna D. Leatherman | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | | 5 min | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) | | | | | | | | | | | |
| <u>asthma</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-15</u> , 19 <u>68</u> , to <u>3-29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>Charles R Wier</u> | | | | | | | | | | <u>4-21-69</u> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Charles R. Wier M.D. | | | | | | Myersville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | April 24, 69 | | Lutheran Cemetery | | | | Middletown Fred. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Gladhill Company | | | | | | Middletown, Md. | | APR 23 1969 | | <u>Charles Wier</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05414

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05407

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Charles Franklin Lewis | | | 2a. DATE OF DEATH April ^{Month} 29 ^{Day} 1969 ^{Year} | | | 2b. HOUR 6 A. M. | | | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH Oct. 30, 1886 | | 6. AGE (In years last birthday) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Fred. Co. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Fred. Md. | | | |
| 10. CITY OR TOWN OF DEATH Thurmont | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Own Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Orchard | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Fred. | | 13c. CITY OR TOWN Thurmont | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER East St. | |
| 14. FATHER'S NAME First J. Hooker Middle Lewis Last | | | 15. MOTHER'S MAIDEN NAME First Laura Middle Kelbaugh Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 215-34-2803 | | 17. INFORMANT Address Helen Hendrickson Thurmont, Md. RD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from May, 1962 , to April 29, 1969 , that (1) (we) last saw the deceased alive on April 15, 1969 , and that (1) (our) opinion of death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE George F. Morningstar MD | | | | 22c. DATE SIGNED 4/30/69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) George Morningstar | | | | 22e. ADDRESS Emmitsburg, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5-2-69 | | 23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State) Thurmont Fred. Co. Md. | | | |
| 24. FUNERAL DIRECTOR Raymond E. Creager | | 25a. REC'D BY REGISTRAR MAY 2 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | First Ruth | | Middle Ellen | | Last Main | | 2a. DATE OF DEATH April Month 7 Day 69 Year | | 2b HOUR a 9:45 M |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH Sept. 22-1905 | | 6 AGE (In years last birthday) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| 7a BIRTH-PLACE (State or foreign country) Md. | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Frederick | | | | Md |
| 10 CITY OR TOWN OF DEATH Frederick | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b COUNTY Frederick | | 13c CITY OR TOWN Frederick | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER Route 4 | | |
| 14. FATHER'S NAME First Middle Last Henry Frederick N. May Frederick | | 15 MOTHER'S MAIDEN NAME First Middle Last Nellie B. Stockman | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b SOCIAL SECURITY NO. (If yes give war or dates of service) 214-48-4402 | | 17 INFORMANT Address Thomas R. Main- Route 4-Frederick-Md.21701 | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, Gland</u> | | | | | | | | | | 3 years |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3-22</u> , 19 <u>64</u> , to <u>4-7</u> , 19 <u>64</u> , that (I) (we) last saw the deceased alive on <u>4-7</u> , 19 <u>64</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Thomas E. Stung</u> | | DEGREE ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 4-7-64 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Thomas E. STUNG | | 22e. ADDRESS Frederick, Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Apr. 10-1969 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick-Frederick-Md.21701 | | | | |
| 24. FUNERAL DIRECTOR M.R. Etchison & Son | | ADDRESS Frederick, Md.21701 | | 25a. REC'D BY REGISTRAR DATE APR 9 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

CERTIFICATE OF DEATH

05409

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|-----------------------|--|----------------|--|-------|--|------|--|----------|--|
| 1 DECEASED NAME (Type or print) | | First | | Middle | | Last | | 2a DATE OF DEATH | | Day | | Month | | Year | | 2b HOUR | |
| Harry | | | | Washington | | May, Sr. | | April | | 20 | | Yrs | | 1969 | | 10:15 PM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | | 8 UNDER 24 HRS | | | | | | | |
| Male | | White | | Sept. 9, 1912 | | 36 YRS | | MONTHS | | DAYS | | HOURS | | MIN | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | U. S. A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Frederick | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Frederick | | Frederick Memorial Hospital | | Driver | | Fred. Iron | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | | | | | | | |
| Maryland | | Frederick | | Route 6 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Route 6 | | | | | | | | | |
| 14 FATHER'S NAME First Middle Last | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | |
| Charles W. May | | Annie V. Roberts | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b SOCIAL SECURITY NO. 213 18 8336 | | 17 INFORMANT Address Mrs. Dorothy May, Route 6, Frederick, Md. | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>571.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Laennec's cirrhosis of liver Severe bronchitis</u> | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner) | | 21b TIME OF INJURY HOUR AM Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | | | | | | | | | |
| 21d NATURE OF INJURY While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC) | | 21f LOCATION Street or RFD No. City or Town County State | | | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4-8-</u> , 19 <u>67</u> , to <u>4-20</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>4-20</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE <u>Rex R. Martin</u> | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED <u>April 21, 1969</u> | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) Rex R. Martin, M. D. | | 22e ADDRESS 220 North Market St. Frederick, Md. | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL, (Specify) Burial | | 23b DATE April 23, 1969 | | 23c NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d LOCATION (City or Town) (County) (State) Frederick Frederick Md. | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland | | ADDRESS Frederick | | 25a RECEIVED BY REGISTRAR APR 23 1969 | | 25b REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of their death.

VR A15 4
45M - 1/65

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--------|-----------------------------|--|---|-----------------------------|--|--|--|---|--|--|
| 05417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05410 | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF ESTI- DEATH MATED | | | 2b HOUR | | |
| Kenneth | | | Miles | | | Month Day Year | | | 6:30 PM | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER, YEAR MONTHS DAYS | 8 IF UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | | |
| Male | White | Feb. 24, 1940 | 29 YRS | | | Month Day Year | | | 6:30 PM | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | Md. | | |
| West Virginia | | U.S.A. | | | | Frederick | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | | Frederick Memorial | | | State Road | | | W. Va. State Road | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? | | |
| West Va. | | | Logan | | | Volyn | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Allen | | | Miles | | | Blanche | | | Raines | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | 233-62-6087 | | | Billy Miles, Chesapeake City, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRANSECTED TRACHEA | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | 6:30 P.M. 4-26-69 | | | | AUTO ACCIDENT | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| | | | | HIGHWAY | | | | Frederick Md. | | | |
| 22a I certify that I took charge of the remains described above, held on death resulted from. | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | EXAMINER'S NAME (Type) | | | | 22b DATE SIGNED | | | |
| Robert J. Thomas | | | | Robert J. Thomas | | | | 4-26-69 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | 5/1/69 | | Forest Lawn Cemetery | | Logan W. Va. | | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a REC'D BY REG STRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Hicks Home for Funerals, Elkton, Md. | | | | | | MAY 6 1969 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 414
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|--|--|--|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 05418 | | | | | | | | | | |
| 05411 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Harvey Allen Miller | | | | | | April 24 1969 | | | 11:30 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| male | | white | | July 7, 1885 | | 83 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARR. ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Wash. Co. | | USA | | | | Frederick | | Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Thurmont | | | Own Home | | | Gardner | | Self-Emp. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Md. | | | Fred. | | Thurmont | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 414 Sabillas ville Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| John Miller | | | Annie Royer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | | | |
| No | | | 219-20-2321 | | Edith M. Miller Thurmont, Md. RD 2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | | | 2 days | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) <u>Terminal general debility</u> | | | | | | | | | 3 mos. | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (I) (a) | | | | | | | | | | |
| <u>Heart disease - Chronic valvular type.</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 15, 1968</u> to <u>Apr. 24, 1969</u> , that (I) (we) last saw the deceased alive on <u>Apr. 23, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| <u>James K. Gray</u> | | <u>April 26-1969</u> | | | | | | | | |
| 22d. PHYSICIAN NAME (Type) | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| James K. Gray | | | | | | | | | | |
| 22e. ADDRESS | | Thurmont, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 4-27-69 | | Church of God Cem. | | Germantown Fred. Co. Md. | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| <u>Raymond E. Creager</u> | | Thurmont, Md. | | <u>Raymond E. Creager</u> | | | | | | |
| | | DATE | | APR 29 1969 | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-10
45M-1A68

05419

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

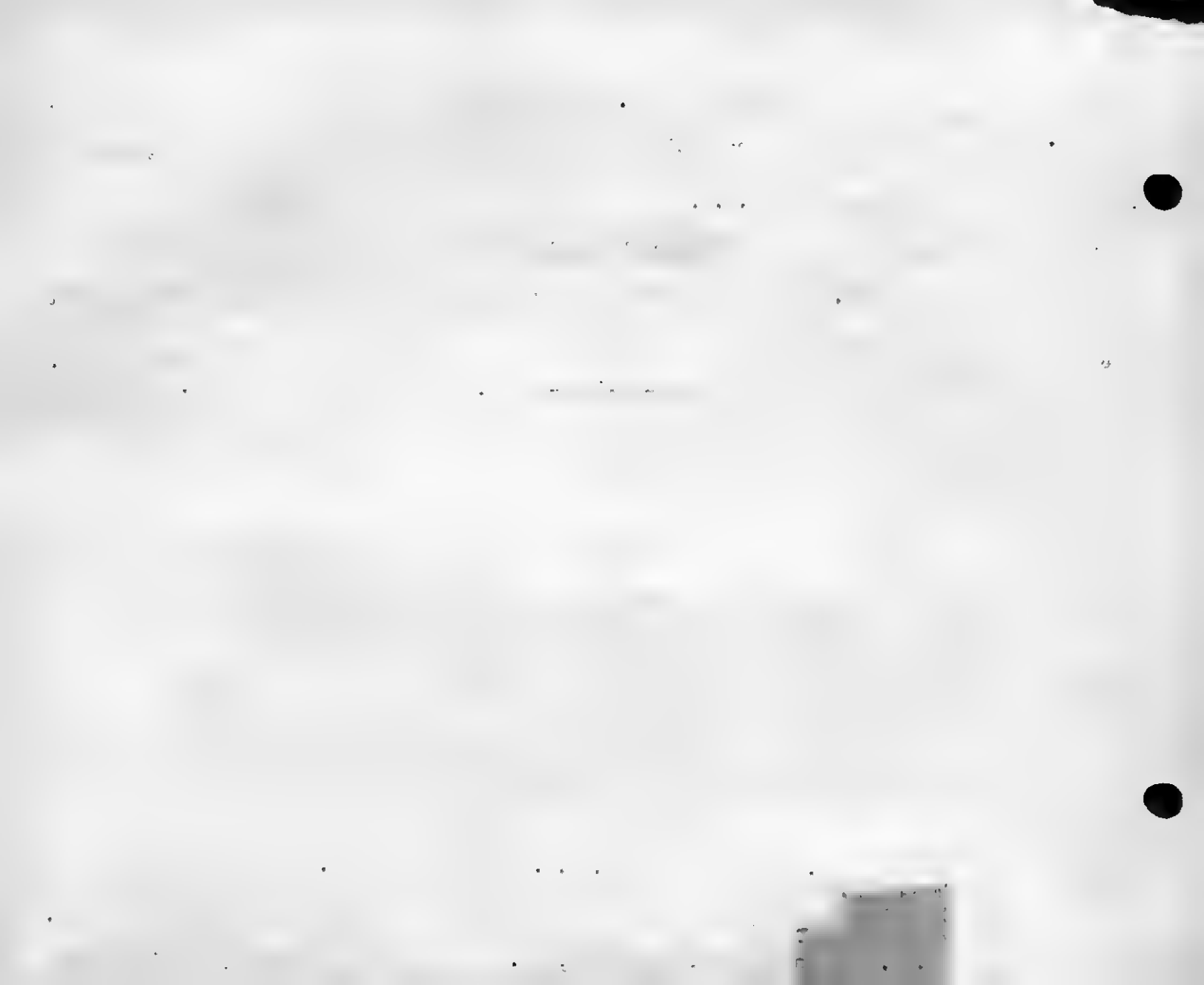
05412

| | | | | |
|---|---|--|--|---|
| 1 DECEASED NAME (Type or print) First Middle Last MATHIAS B. MILLER, SR. | | 2a DATE OF DEATH Month Day Year April 4 1969 | | 2b HOUR 10p/M |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH May 14, 1884 | 6 AGE (in years last birthday) 84 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Frederick Md. | |
| 10. CITY OR TOWN OF DEATH Frederick | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Montevue Infirmary | 12a USLA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) Retired | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | 13b COUNTY Frederick | 13c CITY OR TOWN Frederick | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER 502 South Market Street |
| 14. FATHER'S NAME First Middle Last Franklin Pierce Miller | 15. MOTHER'S MAIDEN NAME First Middle Last Cora Cramer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220 09 3043 | 17 INFORMANT Address Francis R. Miller, Sr. Alexandria, Va. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>5 years</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. ALTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State |
| 22a I certify that (I) (this hospital) attended the deceased from April 30, 1966, to April 4, 1969, that (I) (we) last saw the deceased alive on April 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b SIGNATURE LeRoy T. Davis | | DEGREE M.D. | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | 22c DATE SIGNED April 7, 1969 |
| 22d. PHYSICIAN'S NAME (Type) LeRoy T. Davis, M.D. | | 22e. ADDRESS 228 N. Market St. Frederick, Md. | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE April 7, 1969 | 23c NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | 23d LOCATION (City or Town) (County) (State) Frederick Frederick Md. | |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. | | ADDRESS Fadley | 25a REC'D BY REG STRIP APR 10 1969 | 25b REGISTRAR'S SIGNATURE James J. J... |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1 DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
|---|--|--|--------|--|-------------------|--|----------|--|
| Charles W. Mullican | | | | Month 4 Day 2 Year 69 | | 7:35 ^{PM} | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |
| male | | caucasian | | 8/30/94 | | 74 YRS. | | 74 YRS. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Frederick | | U.S.A. | | | | Frederick | | Md |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | Frederick Nursing Center | | Retired | | Auto parts | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | Frederick | | Frederick | | | | 110 East Eighth Street |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT |
| Charles E/ Mullican | | Louise Brust | | No | | 214-10-1992-A | | Mrs. Mary Mullican, 110 E/8th. Street |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Recent CVA</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1967, to April 2, 1969, that (I) (we) last saw the deceased alive on 4/1/69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | |
| A. Austin Pearce, Jr. | | 4/2/69 | | A. Austin Pearce, Jr. M.D. | | | | |
| 22e. ADDRESS | | 22f. REG'D BY REG-STRAR | | | | | | |
| Toll House Ave. Frederick, Maryland | | DATE APR 7 1969 | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | April 4, 1969 | | Mount Olivet Cemetery | | Frederick Frederick Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. REG'D BY REG-STRAR | | 25b. REG-STRAR'S SIGNATURE | | | | |
| M. R. Echison & Son, Frederick, Md. | | DATE APR 7 1969 | | Charles Judge | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

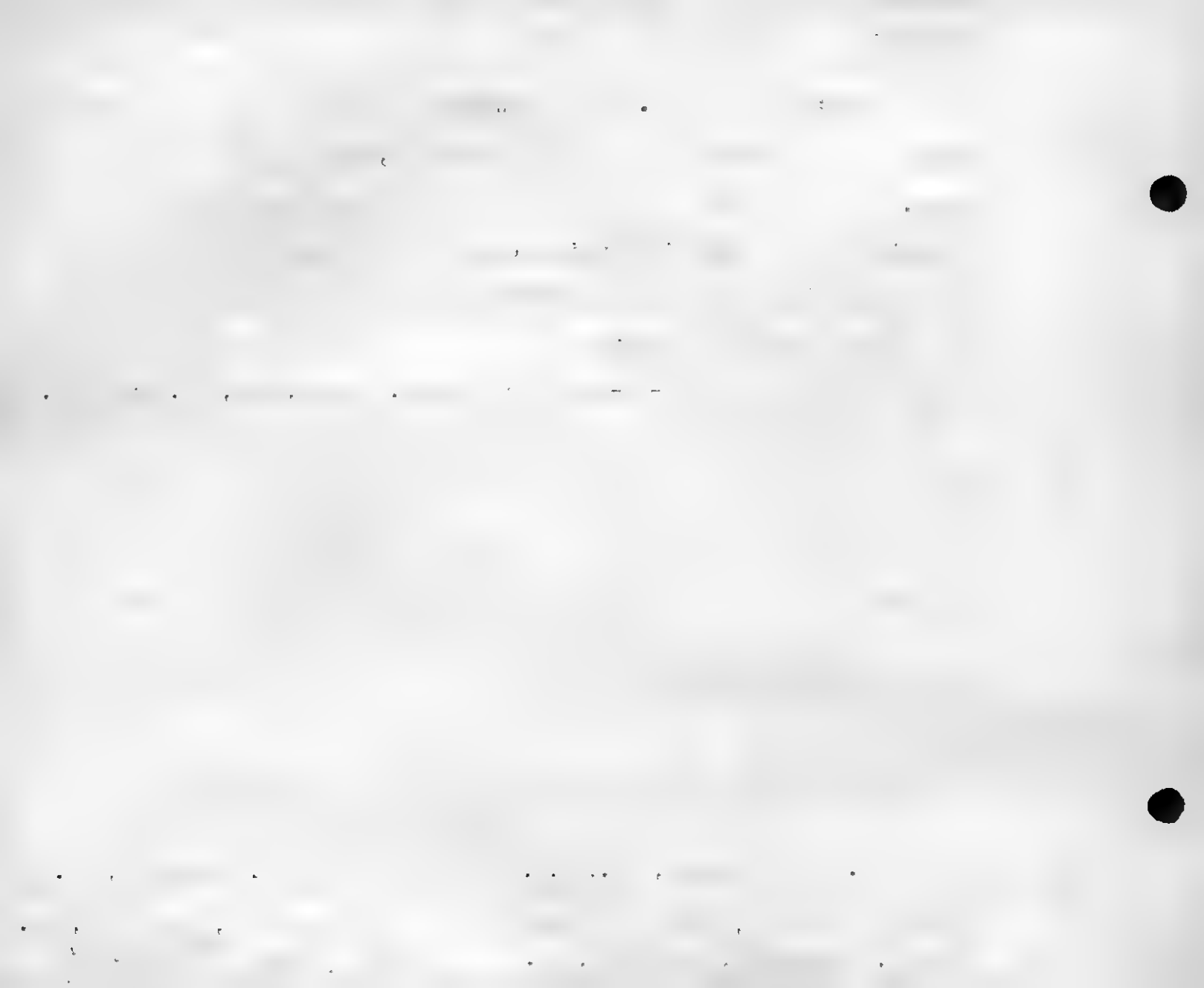
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | | | | | | | | | | |
|---|--------|--|--------|---|--------------------------|--|--------------------------------|---|--------------------------|--|
| 1 DECEASED-NAME (Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | <input type="checkbox"/> Month | Day | Year | 2b. HOUR |
| LINDA | | | GALE | MUMA | ESTIMATED | | <input type="checkbox"/> April | 9, | 1969 | 10:00 |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (in years - last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | |
| Female | White | April 13, 1954 | | 41 YRS | MONTHS | | DAYS | | Month | Day |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | 2d. HOUR | | |
| Maryland | | U.S.A. | | | | Frederick | | 10:00 | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Emmitsburg | | Boyfriend's house near Emmitsburg | | | | Student | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | Frederick | | Emmitsburg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | R.D.# 1 | | |
| 14 FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| Robert W. Muma | | | | | Catherine | | | | Ward | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | | |
| No | | 216-60-7937 | | Robert W. Muma, Emmitsburg, Md. | | R.D.# 1 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wounds of chest | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| CAUSE OF DEATH | | ? P.M. ? 19 ? | | Found shot after boyfriend's house | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| | | House | | | | Emmitsburg-Frederick-M.D. | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | Ronald N. Kornblum, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED |
| | | | | | | | | | | 4/11/69 |
| EXAMINER'S NAME (Type) | | Ronald N. Kornblum, M.D. | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Burial | | April 12, 1969 | | Mt. View | | Emmitsburg, Frederick Co. Md. | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Clarence E. Wilson | | Emmitsburg, Md. | | APR 14 1969 | | Clarence E. Wilson | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retrace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-----------------------------|---|---|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a DATE OF DEATH | | |
| Frances | | | V. | | Nicklas | | April | | Month | Day 3 Year 69 | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | | |
| female | | white | | October 16, 1881 | | | 87 YRS | | IF UNDER 24 HRS | | |
| 7a BIRTH-PLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Penna. | | USA | | | | Frederick | | Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Frederick | | | Frederick Nursing Center | | | Housewife | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | |
| Maryland | | | Frederick | | Mount Airy | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RFD # 3 | | |
| 14 FATHER'S NAME | | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | | |
| Robert Gilliland Vandevort | | | | | | | | | Mary Christina Wilson | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | | | |
| No | | | 167-01-1601 | | Mrs Mary D. Walker, R#3, Mt. Airy, Md. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CVA | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | |
| (b) Ca of breast with metastases | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| Diabetes Mellitus | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | |
| | | | HOUR A.M. Month Day Year | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21a INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC) | | | 21f LOCATION | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March, 1969, to April 3, 1969, that (I) (we) lost saw the deceased alive on 4/2/69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED | |
| A. Austin Pearre, Jr. | | | | | | | | | | 4/3/69 | |
| 22d PHYSICIAN'S NAME (Type) | | | | | | 22e ADDRESS | | | | | |
| A. Austin Pearre, Jr., M.D. | | | | | | 804 Toll House Ave., Frederick, Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCALITY (City or Town) (County) (State) | | | |
| Burial | | | April 7, 1969 | | Uniondale | | | North Side, Pittsburgh, Pa. | | | |
| 24 FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Olin L. Molesworth, | | | | | | Damascus, Md. | | DATE APR 7 1969 | | Charles Judge | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05423

05416

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|---|-----------------------------------|--|--|---|--|
| 1. DECEASED NAME (Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year DEATH MATED <input type="checkbox"/> Apr 19, 1969 | | 2b. HOUR M |
| 3 SEX Male | | 4 RACE White | 5 DATE OF BIRTH March 16, 1914 | 6 AGE (in years last birthday) 55 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD Month Day Year Apr 19, 1969 | 2d. HOUR M |
| 7a. BIRTHPLACE (State or foreign country) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick County Md | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital (DOA) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Doorkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY Sheet Metal Co | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia | | 13b. COUNTY Arlington | | 13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1922 N. Veitch Street | |
| 14. FATHER'S NAME First Middle Last Harry Saunders Saunders | | 15. MOTHER'S MAIDEN NAME First Middle Last Bertha Fry | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO (If yes give year or dates of service) 578-07-8656 | | 17. INFORMANT ADDRESS Arl., Va. Richard Saunders-Son 804 N. Cleveland St., Va. | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED SKULL DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A M P M 4-19 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) AUTO LEFT ROAD & OVERTURNED | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway | | 21f. LOCATION Street or R.F.D. No City or Town County State US 40A at 70S - FREDERICK-FREDERICK-MD | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Robert J. Wouner M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED 4-19-69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Apr. 23, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City or Town) (County) (State) Fairfax, Virginia | |
| 24. FUNERAL DIRECTOR C. M. Gurnel Murphy Funeral Home, 3524 Columbia Pike, Va. 22204 | | ADDRESS Arl., Va. | | 25a. REC'D BY REGISTRAR APR 22 1969 | | 25b. REGISTRAR'S SIGNATURE M. L. S. Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4319

1

05424

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05417

| | | | | | | | | | |
|---|--|---|---|--|---|---|--|--|--|
| 1 DECEASED-NAME (Type or print) Dorothy Blanche Shank | | | 2a. DATE OF DEATH Month April Day 30 Year 1969 | | | 2b. HOUR 6 AM | | | |
| 3. SEX Female | | 4 RACE White | | 5. DATE OF BIRTH Feb. 2, 1911 | | 6. AGE (In years last birthday) 58 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick Md. | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Men. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Middletown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Route 40A R.F.D.1 | |
| 14. FATHER'S NAME First Harlan Middle Schildnecht Last Alberta | | | 15. MOTHER'S MAIDEN NAME First C. Middle Dutrow Last Route #1 | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) ----- | | | |
| 16b. SOCIAL SECURITY NO 217-28-0843 | | | 17. INFORMANT Charles A. Shank | | | Address Middletown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per Part 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4319 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/25/69 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 25 Apr 1969 , to 30 Apr 1969 , that (I) (we) last saw the deceased alive on 29 Apr 1969 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Charles H. Conley, Jr. M.D. | | | | DEGREE M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 2 May 1969 | |
| 22d. PHYSICIAN'S NAME (Type) Charles H. Conley Jr. M.D. | | | | 22e. ADDRESS Professional Bldg. Frederick, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 3, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | | 23d. LOCATION (City or Town) (County) (State) Middletown Fred. Md. | | | |
| 24. FUNERAL DIRECTOR Gladhill Company | | | | ADDRESS Middletown, Md. | | 25a. REC'D BY REG-STRAR MAY 5 1969 | | 25b. REGISTRAR'S SIGNATURE Charles J. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15
45M - 1/29

| 05425 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | CERTIFICATE OF DEATH | | 05418 | |
|---|--|---|--|---|--|---|--|
| 1 DECEASED NAME (Type or print) Paul | | First Wilson | | Middle Shank | | 2a. DATE OF DEATH April Month 1 Day 69 Year | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 23, 1913 | | 6. AGE (In years lost birthday) 55 YRS | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Frederick | |
| 10. CITY OR TOWN OF DEATH Frederick | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY County Rd. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Middletown | | 13d. INSIDE CITY LIM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Roma Luther | | Middle Shank | | 15. MOTHER'S MAIDEN NAME First Annie | | Middle Delauter | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO 212-24-5987 | | 17. INFORMANT Irene Schroyer Hagerstown, Md. | | Address 824 Pine St. | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4861 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Myocardia & Pericarditis DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 29 MAR , 19 69 , to 31 MAR 19 69 , that (I) (we) last saw the deceased alive on 31 MAR 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE George I. Smith Jr. | | 22c. DATE SIGNED 1 Apr 69 | | 22d. PHYSICIAN'S NAME (Type) George I. Smith Jr. M.D. | | | |
| 22e. ADDRESS 804 Toll House Ave Frederick Md. | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE April 3, 69 | | 23c. NAME OF CEMETERY OR CREMATORY Grossnickle Cemetery | | 23d. LOCATION (City or Town) (County) (State) Ellerton Fred. Md. | |
| 24. FUNERAL DIRECTOR Gladhill Company | | ADDRESS Middletown, Md. | | 25a. REC'D BY REGISTRAR APR 3 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

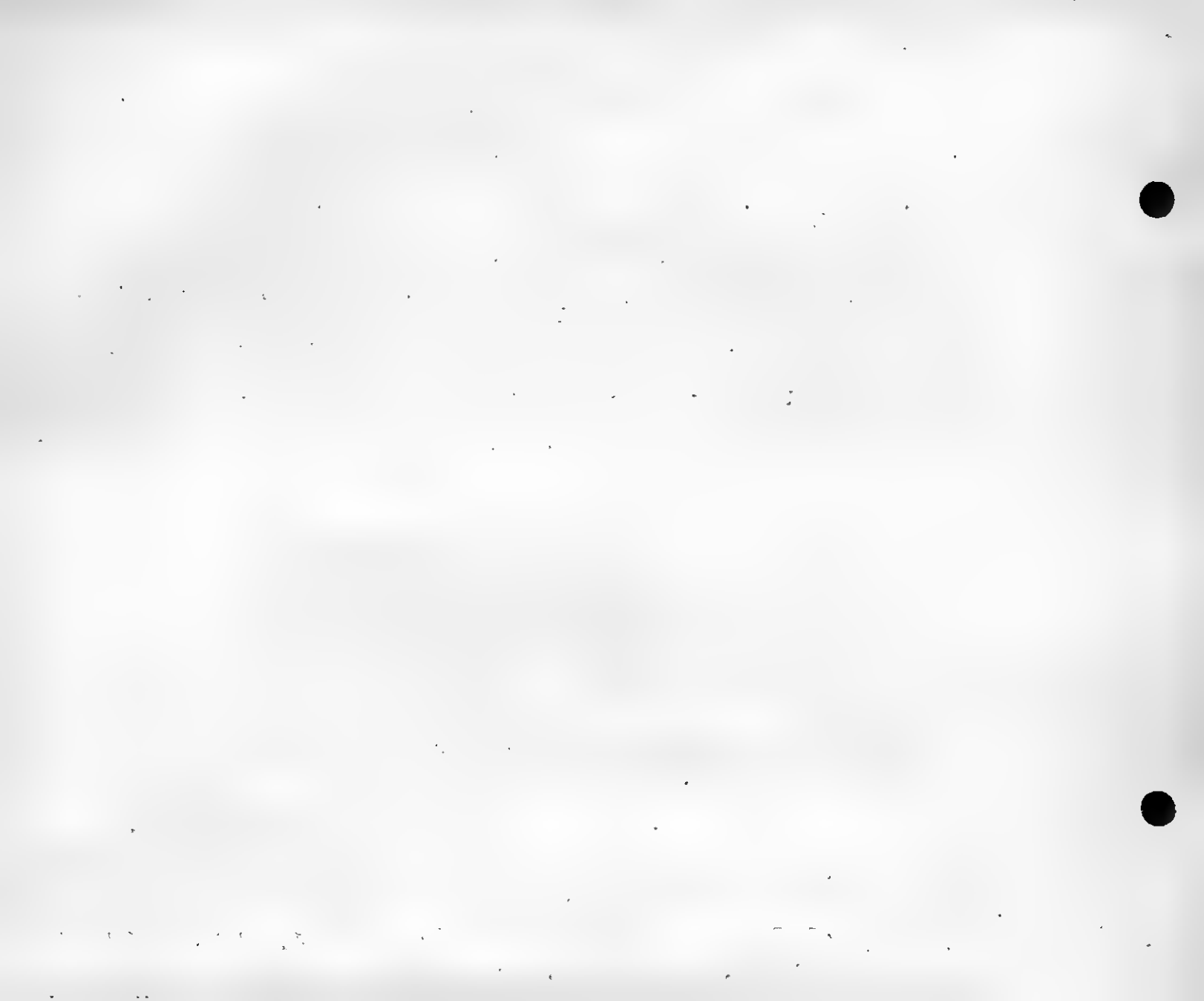
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First AUBREY | | | Middle SMITH | | | Last | | | 2a. DATE OF DEATH April Month 29 Day 1969 Year | | | 2b. HOUR 5:30 P.M. | | |
| 3. SEX M | | | 4. RACE W | | | 5. DATE OF BIRTH May 3, 1894 | | | 6. AGE (In years last birthday) 74 YRS. | | | F UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Frederick Md | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY City of Frederick | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut an admission) STATE Maryland | | | 13b. COUNTY Frederick | | | 13c. CITY OR TOWN Frederick | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 40 Tancy Apts. | | | | | |
| 14. FATHER'S NAME Oliver | | | First Smith | | | Last | | | 15. MOTHER'S MAIDEN NAME Louisa | | | First Foreman | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) yes WWI | | | 16b. SOCIAL SECURITY NO 214-10-3385 | | | 17. INFORMANT Mrs Mary R Smith, 40 Tancy Apts, Fred, Md. | | | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHIO PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHIOGENIC CARCINOMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. F YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/25/69, to 4/29/69, that (I) (we) last saw the deceased alive on 4/29/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Robert S. Hughes | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) ROBERT S. HUGHES | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 5/2/69 | | | 23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) W. Woodsboro, Fred, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Y. C. Barton, Walkersville, Md. | | | ADDRESS | | | | | | 25a. REC'D BY REGISTRAR MAY 5 1969 | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--------|---|------|--|---|---------------|--|--|--------|--------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | | | | |
| JESSE | | | A. | | SMITH | | | | | April 8, 1969 | | | 0200AM | | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (in years last birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| Male | | | Cau | | | 4 August 1921 | | | 47 YRS. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | |
| Independence, West | | | U.S. | | | | | | Frederick | | | | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Frederick | | | 223 South Market Street | | | Guard | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | |
| Maryland | | | Frederick | | | Frederick | | | YES | | | 223 South Market Street | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| George | | | E. Smith | | | Henrietta Dinterman Smith | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | | | | | |
| Yes | | | 1942-1964 | | | 213-16-0736 | | | Mrs. Betty Smith | | | 223 South Market Street | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> | | | | | | | | | | | | 10 minutes | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | |
| (b) <u>Arteriosclerotic heart disease</u> | | | | | | | | | | | | 15 months | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | |
| <u>Diabetes mellitus</u> | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>1 November, 1967</u> , to <u>Present</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>3 April 1969</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | MD DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | | | | | |
| <u>Theodore S. Herman</u> | | | | | | | | | 8 April 1969 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | |
| THEODORE S. HERMAN, CPT, MC | | | USAMRIID, Ft Detrick, Frederick, Md. 21701 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | 4-11-1969 | | | Mount Olivet Cemetery | | | Frederick, Frederick, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| <u>Robert E. Dailey & Son</u> | | | Frederick, Maryland | | | APR 14 1969 | | | <u>W. Charles Under</u> | | | | | | | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 M
30M REV 1/68

05428

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05421

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Nettie Ellen Stottlemyer | | | 2a. DATE OF DEATH April 17 Day 1969 | | | 2b. HOUR 6:00 M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Dec. 18, 1894 | | 6. AGE (In years last birthday) 74 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Carroll Co. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Frederick Md | | | |
| 10. CITY OR TOWN OF DEATH Woodsboro | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Own Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b. COUNTY Fred. | | 13c. CITY OR TOWN Woodsboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last Charles A. Stultz | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Alice R. Hildebride | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO None | | 17. INFORMANT Address Glenn F. Stottlemyer Woodsboro, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarct | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hr 4 MON 745 5 MON 745 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetic Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/25 , 19 67 , to 4/16 , 19 69 , that (I) (we) last saw the deceased alive on 4/16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Julius Chopko MD | | | | DEGREE MD | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 7/18/69 | |
| 22d. PHYSICIAN'S NAME (Type) Julius Chopko | | | | 22e. ADDRESS 852 W. 1000 ST Westminister | | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) Burial | | 23b. DATE 4-20-69 | | 23c. NAME OF CEMETERY OR CREMATORY Church of Brethren Cem. | | 23d. LOCATION (City or Town) (County) (State) Rocky Ridge Fred. Co. Md | | | |
| 24. FUNERAL DIRECTOR Raymond E. Greager | | | | ADDRESS Thurmont, Md. | | 25a. RECEIVED BY REGISTRAR APR 22 1969 | | 25b. REGISTRAR'S SIGNATURE William L. Under | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

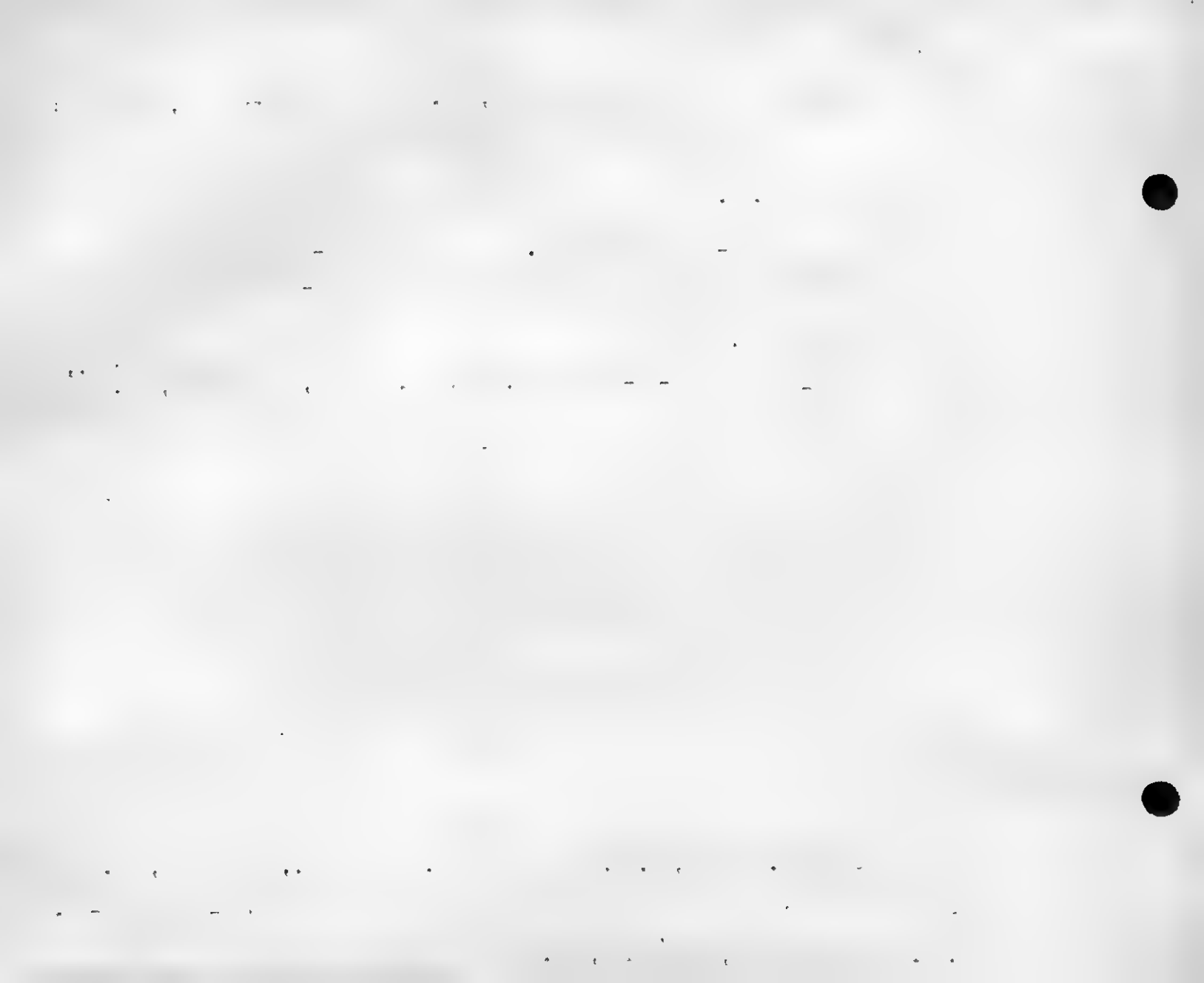
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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| MARIAN LEE SNOWLEY | | | | | | 4 23 69 | | | M |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| FEMALE | | WHITE | | JULY 2, 1881 | | | 87 YRS | | IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTH-PLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| FREDERICK | | U.S.A. | | | | FREDERICK Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| IJAMSVILLE/ FREDERICK | | | FREDERICK MEM. HOSP | | | HOUSEWIFE | | | AT HOME |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY, JAN 1957 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER | | |
| MD. | | | FREDERICK | | IJAMSVILLE | | RT. # 1 | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| THOMAS LEE CRAWFORD | | | SALLY E. HOOD | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on or after (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| NO | | | 214-48-2543 | | MARY CRAWFORD CROMWELL FREDERICK, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility with cerebral + arteriosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF <u>heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1957, to 4-23, 1969, that (I) (we) last saw the deceased alive on 4-22-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Rex R. Martin MD</u> | | | | | 22c. DATE SIGNED 4-23-69 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Rex R. Martin | | | | | 22e. ADDRESS Frederick, Md | | | | |
| 23a. BURIAL CREMATION, Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> | | 23b. DATE 4-26-69 | | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM | | | 23d. LOCATION (City or Town) (County) (State) FREDERICK FRED. MD. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |
| SALANONE FUNERAL HOME FREDERICK, MD. | | | | | APR 28 1969 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|-------|---|---|--|--|-------------------------------|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a DATE OF DEATH | | | 2b HOUR |
| BERNARD OSCAR THOMAS, SR. | | | | | | Month Day Year April 15, 1969 | | | 6:15AM |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | White | | 6 Nov 1882 | | 86 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U. S. | | | | Frederick Md | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Frederick | | 6-A Parkview Apts. | | Retired - Medical Doctor | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Maryland | | Frederick | | Frederick | | | | 6-A Parkview Apartments | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| David D. Thomas | | | | | | Harriett Trundle | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Longest time heart failure</u> 442X | | | |
| Yes | | WW-I | | Dr. James B. Thomas, 905 Rosemont Ave., Frederick, Md. 21701 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>today</u> | | | |
| | | | | | | (b) <u>Cor pulmonale</u> 3 years | | | |
| | | | | | | (c) <u>Chronic pulmonary emphysema</u> 10 years | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>15 April</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>14 April</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| James B. Thomas, M.D. | | 15 April 1969 | | James B. Thomas, M. D. | | | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | | | |
| | | 228 N. Market St., Frederick, Md. 21701 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 4/17/69 | | Mount Olivet Cemetery | | Frederick-Frederick-Md. | | | |
| 24. FUNERAL DIRECTOR | | 24a. ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Frank A. Smith, Jr. | | M. R. Etchison & Son, Frederick, Md. 21701 | | APR 17 1969 | | Charles Judge | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 412 State Department of Health
-29-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05424

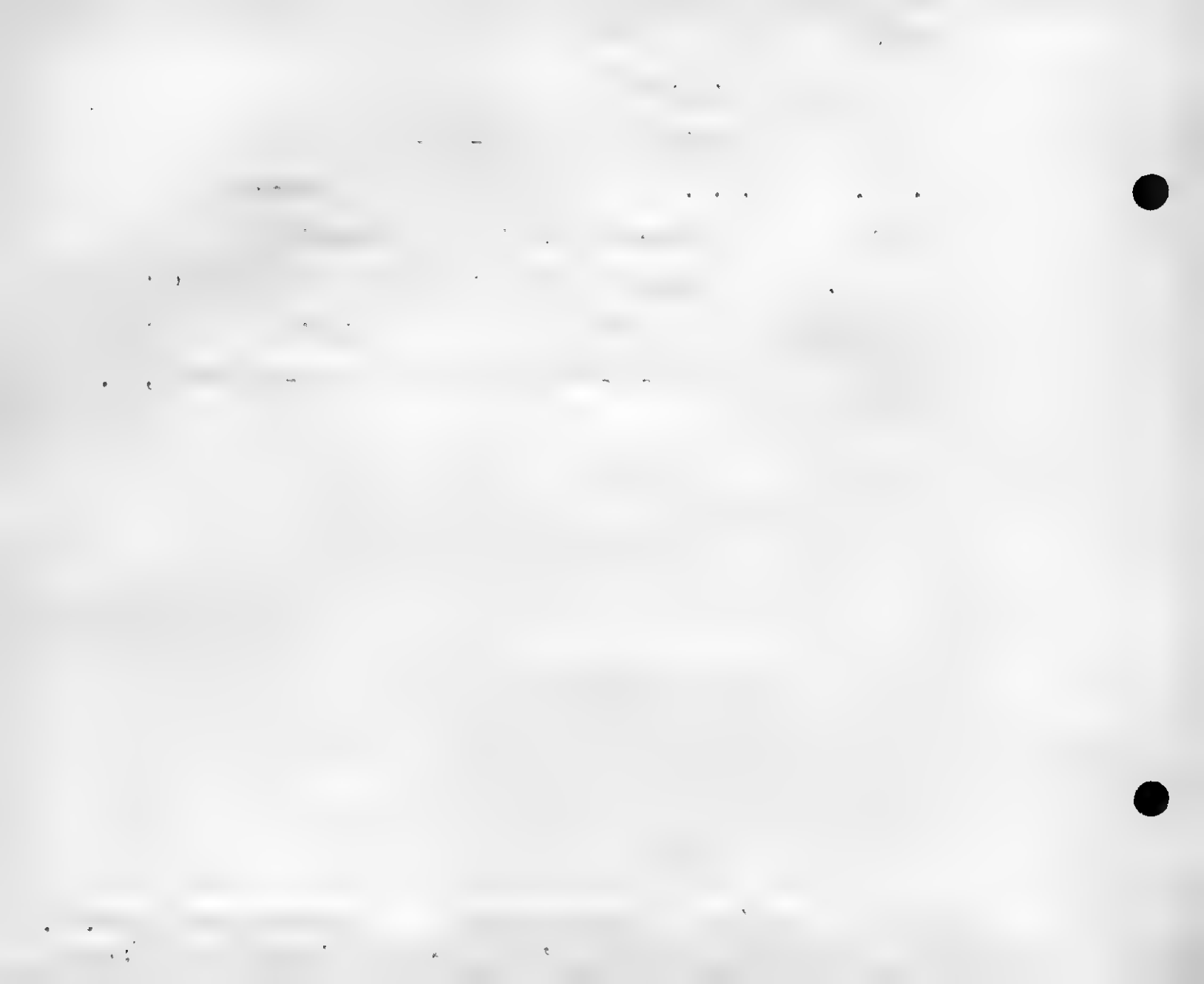
| | | | | | | | | | | | | | | | | | |
|--|--|--------|--|--|--|--------------------------------|--|--|--|-----------------|--|---|--|------------------------|--|---|--|
| 1 DECEASED NAME (Type or Print) | | | | First Middle Last | | | | 2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 4-9-1969 P M | | | | 2b HOUR | | | | | |
| James Calvin Thompson | | | | | | | | | | | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | F UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | 2d HOUR | | | |
| Male | | Negro | | 11-1-1914 | | 54 YRS | | MONTHS | | DAYS | | 4 10 Day Year 1969 P M | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 COUNTY OF DEATH | | | | | |
| Maryland | | | | U.S.A. | | | | | | | | Frederick Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Ijamsville | | | | Centerville, Ijamsville | | | | | | | | Construction | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 13d INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Md | | | | Frederick | | | | Ijamsville | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Ijamsville F.O. Md | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| James Luther Thompson | | | | Melerna Sarah Keays | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| Yes | | | | W.W.11 | | | | 213-12-5095 Mrs Clipertina Campbell 401 Carrollton | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration asphyxia, vomitus | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20 AUTOPSY? | |
| | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | |
| | | | | 19 P.M. | | | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | | | |
| EXAMINER'S NAME (Type) Robert R. Roberts | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 12 APR 69 | | | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | Frederick, Md | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | | 4-14-1969 | | | | Ebernezer Church | | | | Ijamsville Fred. Md | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | 25a REC'D BY REG STRAR | | | | | | | | 25b REG STRAR'S SIGNATURE | |
| C.E. Hicks, 111 Frederick, Maryland | | | | | | | | DAT APR 15 1969 | | | | | | | | W. C. Hicks, Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 05432 | | DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05425 | |
| 1 DECEASED-NAME (Type or print) <i>Bessie Lillian</i> First Middle Last | | | | 2a. DATE OF DEATH Month <i>4</i> Day <i>8</i> Year <i>69</i> | | 2b. HOUR <i>M</i> | |
| 3 SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>9-15-96</i> | | 6 AGE (in years) <i>72</i> (months) <i>0</i> (days) <i>0</i> (hours) <i>0</i> (minutes) | |
| 7a. BIRTHPLACE (State or foreign country) <i>W. Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH <i>Frederick</i> | |
| 10 CITY OR TOWN OF DEATH <i>Frederick</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital) <i>Frederick Memorial</i> | | 12a. USJA. OCCUPATION (Kind of work done during life, even if retired) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USJA. RESIDENCE (Where deceased lived, if not in hospital) STATE <i>Md.</i> | | 13b. COUNTY <i>Frederick</i> | | 13c. CITY OR TOWN <i>Brunswick</i> | | 13d. STREET AND NUMBER <i>823 East 'A' Street</i> | |
| 14. FATHER'S NAME First <i>Edward</i> Middle <i>Griffith</i> Last | | 15. MOTHER'S MAIDEN NAME First <i>Minnie</i> Middle <i>Seibert</i> Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <i>no</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>213-24-8947</i> | | 17. INFORMANT <i>William Wilson -Brunswick, Md.</i> Address | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Shock</i> 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Ventricular tachycardia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i> <i>10 years</i> |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 4</i> , 19 <i>65</i> , to <i>April 8</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>April 8</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (aid not) view the body after death | | | | | | | |
| 22b. SIGNATURE <i>Henry V. Chase M.D.</i> | | 22c. DATE SIGNED <i>4/8/69</i> | | 22d. PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i> | | | |
| 22e. ADDRESS <i>804 Toll House Frederick Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>4/11/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Dargan Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Samuels Manor Wash. Md.</i> | |
| 24. FUNERAL DIRECTOR <i>Peete Funeral Home</i> | | 24b. ADDRESS <i>Brunswick, Maryland</i> | | 25. REC'D BY REGISTRAR <i>APR 10 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>William Judge</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a general director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1
30M REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|---|--|--|---|---|--|---|--------------------------------|---|-------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Orpha May Wellard | | | | | | 2a. DATE OF DEATH Month Day Year April 17 1969 | | | 2b. HOUR P 6:00 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Feb. 12, 1871 | | | 6. AGE (In years month day) 98 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Fred. Co. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Frederick | | | Md. | | | |
| 10 CITY OR TOWN OF DEATH Thurmont rural | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Own Home | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b KIND OF BUSINESS OR INDUSTRY Own Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md. | | 13b COUNTY Fred | | 13c. CITY OR TOWN Thurmont | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER RD 1 | | | | |
| 14. FATHER'S NAME First Middle Last Thomas Eyer | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sarah Cline | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b SOCIAL SECURITY NO (If yes give war or dates of service) 220-52-1941 | | 17. INFORMANT Address Mrs. Leotta Reed Thurmont, Md. RD 1 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart disease, arteriosclerotic type DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. 10 years | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none other than old age debility and exhaustion. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 1 , 19 68 , to April 17 , 19 69 , that (I) was last saw the deceased alive on April 16 19 69 , and that in (my) your opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE James K. Gray | | | | DEGREE James K. Gray | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED April 17-1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type) James K. Gray | | | | 22e. ADDRESS Thurmont, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4-20-1969 | | 23c. NAME OF CEMETERY OR CREMATORY United Brethren Cem. | | | 23d. LOCATION (City or Town) (County) (State) Thurmont Fred. Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR Raymond E. Creager | | | | ADDRESS Thurmont Md. | | 25a. REC'D BY REGISTRAR 22 1969 | | 25b. REGISTRAR'S SIGNATURE William J. Under | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

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|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 05434 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 05427 | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last ALTIA MAY WRIGHT | | | | | | | | | | | | 2a. DATE OF DEATH 19 April Month Day Year 69 | | | | | | | | | | | | 2b. HOUR 11:55 A.M. | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | | 4. RACE Caucasian | | | | | | 5. DATE OF BIRTH June 7, 1902 | | | | | | 6. AGE (In years last birthday) 66 YRS. | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 9. COUNTY OF DEATH Frederick, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Frederick | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | | 13b. COUNTY Frederick | | | | | | 13c. CITY OR TOWN Rural Fred. | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 13e. STREET AND NUMBER Route # 5 Frederick | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Charles Winpigler | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Ida Hamilton | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No | | | | | | | | | | | | 16b. SOCIAL SECURITY NO 219-03-5540 | | | | | | 17. INFORMANT Address Mrs. Charles Walters Rt. # 5 Frederick, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 485X DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Congestive heart failure; idiopathic leukopenia</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | 19a. DATE OF OPERATION | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>68</u> , to <u>April</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>19 April</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>George I. Smith Jr. M.D.</u> | | | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED <u>20 April 69</u> | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. George I. Smith, Jr. M.D. | | | | | | | | | | | | 22e. ADDRESS Toll House Avenue Frederick, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 23b. DATE 4-23-1969 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | | | | | 23d. LOCATION (City or Town) (County) (State) Frederick, Frederick, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Robert E. Dailey & Son</u> | | | | | | | | | | | | ADDRESS Frederick, Maryland | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE <u>APR 22 1969</u> | | | | | | 25b. REGISTRAR'S SIGNATURE <u>W. C. M. Judge</u> | | | | | | | | | | | |

GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05435

05428

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) FLORA | | | First Middle Last MAE WRIGHT | | | 2a. DATE OF DEATH April Month 3 Day 1969 Year | | | 2b. HOUR 9 a.m. | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH Jan. 10, 1885 | | | 6. AGE (In years last birthday) 84 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Frederick Md. | | |
| 10. CITY OR TOWN OF DEATH Nr. Jefferson, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Nr. Jefferson | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if in institution: Residence before admission) STATE Maryland | | | 13b. CITY OR TOWN Frederick | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER Nr. Jefferson | | |
| 14. FATHER'S NAME First Middle Last John Harris | | | 15. MOTHER'S MAIDEN NAME First Middle Last (Unknown) | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO. 219 03 1746 | | | 17. INFORMANT Address Mrs. Mary Wolfe, Route 5, Frederick, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic C.V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes 5 yrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1962 to April 4, 1969 , that (I) (we) last saw the deceased alive on March 31, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Leroy T. Davis | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED April 4, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) Leroy T. Davis, M. D. | | | | | | 22e. ADDRESS 228 N. Market Street, Frederick, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE April 5, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md. | | |
| 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. | | | | | | 25a. RECEIVED BY REGISTRAR APR 8 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | |

